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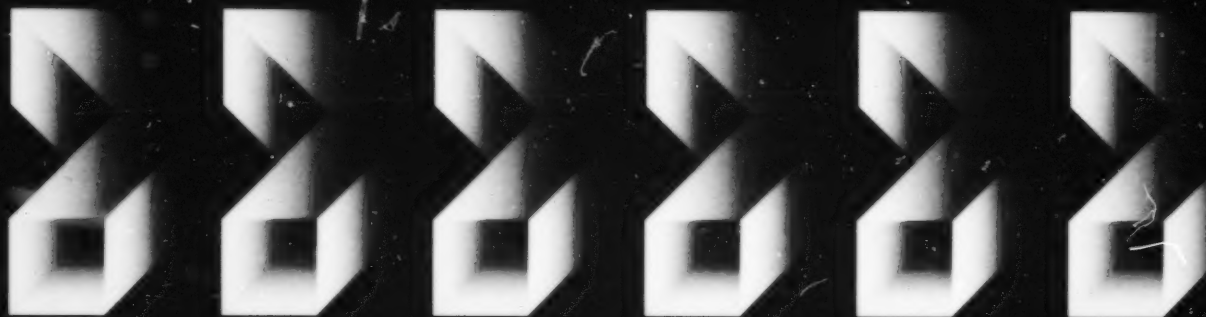
Groupe de l'évaluation

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de la consultation**



**Evaluation of the Division of Aging and
Seniors/Seniors Strategy
Revised First Interim Report**

September 1996

Canada

MISSION STATEMENT

**The Evaluation Group
helps Health Canada serve
Canadians better by
providing objective information
and advice about the
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**Le Groupe de l'évaluation
aide Santé Canada à mieux servir
les Canadiens et les Canadiennes
en offrant une information et des
conseils objectifs sur l'efficacité
des activités et des services
du Ministère.**

**Evaluation of the Division
of Aging and Seniors/Seniors Strategy
Revised First Interim Report**

September 4, 1996

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CHAPTER

1

INTRODUCTION

In 1994, a Seniors Directorate was created in Health Canada, merging the majority of the Department's seniors programs, including the major elements of the Seniors Strategy. The Seniors Directorate was later renamed the Division of Aging and Seniors (DAS) following a restructuring of the Health Promotion and Programs Branch. In order to reflect the fact that the Division of Aging and Seniors and the Seniors Strategy are connected, the expression Division of Aging and Seniors/Seniors Strategy (DAS/S) is used. It is the responsibility of the Division of Aging and Seniors to implement the Seniors Strategy. This responsibility is undertaken through its own operations as well as through the activities of its partners, such as the Health Promotion and Programs Branch Regional Offices, the Extramural Research Division, the National Advisory Council on Aging (NACA) and the Health Policy Directorate. There are four program elements within DAS/S: Seniors Community Programs Funding; Seniors Independence Research Program (SIRP); policy coordination and support to the Minister; and support to NACA. A more complete history and description of the context of the DAS/S are presented in a later chapter.

This report presents the results of the literature review, the review of baseline data and the file review conducted to date as part of the evaluation of the

DAS/S. A review of the literature and baseline data is an important component of the overall evaluation initiative as it provides contextual information for the assessment of the relevance, need for and success of the DAS/S. The literature review also involved an examination of initiatives and strategies in other western industrialized countries in an effort to compare the initiatives undertaken in Canada to those in other countries. An additional important purpose of the literature and baseline data review component of the evaluation was to provide a foundation for the analysis of evaluation result and to refine the study team's understanding of the issues and background to Health Canada's programs under the DAS/S. Through the review of project files, information will be obtained on the activities, outputs, success and focus of projects undertaken to address the needs of Canadian seniors.

The purpose of this report is to describe the methodological approach used in the literature, baseline data and file reviews, and to present the findings. The report contains six additional chapters. The remainder of this first chapter discusses the approach taken for each of the literature, baseline data and file reviews. The second chapter presents an overview of the changes that have occurred over the past 10 years regarding the health, well-being and independence of seniors in Canada and highlighting their current situation. A comparison to other "at risk" groups is also presented in this chapter. The focus of Chapter Three is on the mandate of Health Canada, the role of the provinces in the field of seniors, and possible options for addressing the needs of seniors as suggested in the literature. This chapter on possible options for addressing the needs of seniors is followed by a description of Health Canada's Division of Aging and Seniors/Seniors Strategy. Chapter Five presents the analysis of the file review conducted on a sample of projects undertaken by certain program elements of the DAS/S. The next chapter outlines strategies and initiatives other than the DAS/S that are currently being implemented in the provinces/territories as well as other western industrialized nations. The final chapter provides an overall

summary of the report highlighting areas that will need to be addressed in the interviews.

1.1 Methodology and Approach

(a) Literature Review

The objectives of the literature review, as stated in the Workplan, were as follows:

- ❑ to provide a foundation for the analysis, including current thinking on major trends and issues and the identification of seniors' needs;
- ❑ to benefit from any previous evaluation work on these or similar programs, either here in Canada or in other countries;
- ❑ to refine the study team's understanding of the key issues and facilitate the formulation of questions to be used in the interviews and the surveys; and
- ❑ to allow the evaluation to benefit from any new findings in fields affecting seniors and an aging population, including a focus on possible alternatives to the DAS/S.

As it is very easy to lose perspective when one is in the midst of a literature review, a detailed outline was drafted prior to commencement of the review, in order to keep the review as focused as possible.

Literature was obtained from a number of sources. Background literature on the Division of Aging and Seniors/Seniors Strategy and its program elements, as well as other relevant materials, such as information on international strategies, was provided by the DAS. There were also a number of documents cited in the Request

for Proposal which were reviewed. Finally, the holdings of the Health Canada and other libraries were examined for relevant materials and bibliographic and citation indices were utilized to locate academic works.

(b) Baseline Data Review

The DAS/S has contributed to the planning and the sampling of three surveys:

- ☐ the General Social Survey¹;
- ☐ Ageing and Independence²; and
- ☐ the Elder Monitor³.

The purpose of reviewing the data from these surveys was to establish baseline data for the evaluation. The information from these surveys will also be important for establishing baseline data to contribute to the measurement of changes over time for subsequent efforts.

Prior to reviewing the data from the surveys, survey items were compared to the performance indicators developed for the evaluation framework in order to determine what data would be pertinent to the evaluation. The various indicators identified for each baseline data base are presented in Table 1.1. Due to the complexity and format in which the information from the General Social Survey was

1. Statistics Canada, *General Social Survey: Cycle 1 Health (1985) — Health and Social Support; Cycle 4 Health (1991) — Where does time go; Cycle 8 Health (1994) — Health status of Canadians; Cycle 9 Health (1994) — Family and friends.*
2. Statistics Canada, *Survey on Ageing and Independence*, 1993.
3. The annual *Elder Monitor* survey, conducted by Synergistics Consulting, 1996.

received, indicators identified from the General Social Survey are not presented in this document.

(c) File Review

The purpose of the project file review was to provide qualitative and quantitative data on the activities and outputs of the projects within each program element. The original intention of this review was to examine project evaluations which would have provided information on project success as well as provide insight into process issues. Unfortunately, evaluations do not exist for the vast majority of projects and so information was taken from individual project files.

Projects were sampled from all four of the DAS/S' program elements. The breakdown of the sampling and files that have been reviewed to date are presented in the table below. While some of the project elements can be traced back as far as the early 1970s, it was decided to only sample those projects that have been undertaken in the past five years to coincide with the timeframe under consideration for the overall evaluation.

TABLE 1.1

Baseline Data Base	Indicators
Elder Monitor n=1200 age: 50+ Feb 1996	☐ Socio-demos (age (#1); marital status (#2); employment (#3); occupation during working life (#D1); education (#D2); province (#D3); population of community (#D4); gender (#D5); HH income (#D6); personal income (#D7) ☐ Factor which contributes most to health and general well being (#4) ☐ Typical week, hours at each activity (e.g., working at a paid job; caring/helping family/friends/neighbors; volunteer; spending time with family; spending time with friends; exercise; watching television) (#5a-g) ☐ Have a close with whom can talk to or call in emergency: number (#6a,b) ☐ Member of seniors group (#7) ☐ Number of times injured in a fall (#45) ☐ Description of home (#48) ☐ Adequacy of current income in meeting needs and wants (#102) Personal Support ☐ Preferences for reliance on others (#55) ☐ If not available from family etc, preferences for reliance on others (#56) ☐ Likelihood to paying for personal care/home maintenance services as-needed basis (#57) ☐ Participating in a program with a monthly fee to receive help and personal care in the future (#58) Health ☐ Frequency of days limited in activity in past year due to mental or physical health (#59) ☐ Frequency of visits to doctor/hospital/clinic in the last year (#60) ☐ Nature of most serious health problem over the last year (#61) ☐ Health status — diagnosed with various conditions (e.g., heart condition/high blood pressure; arthritis; skeletal/back problems/osteoporosis; joint disorders; diabetes; lung disorder; cancer; shingles; thyroid; eye problems; high cholesterol; gastro-intestinal; anxiety/depression) (#62) ☐ Activity limitations due to long-term illness/physical condition (#63) Pharmaceutical/Nutriceutical usage ☐ Vitamin/nutritional supplement usage (#65) ☐ Number different prescriptions for pills/medicine currently have filled (#66) ☐ Number non-prescription pills/treatments used in a typical week (e.g., pain killers; cold remedies; sleeping pills; vitamins; antacids; calcium/iron/other minerals) (#70) ☐ Interest in mood/personality elevators (#71) ☐ Interest in practice of alternative medicine (#72)

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Baseline Data Base	Indicators
Survey on Ageing and Independence 1991 n=20,000 age=45+	Security ☐ Frequency in previous month afraid for physical safety/security due to crime/other conditions in immediate community, have personal habits changed due to fears (#64a,b) ☐ Source credibility for information concerning drugs/medication, apart from doctor/pharmacist (#69) Attitudes ☐ Opinion of which one group in society needs to be protected from government cut-backs (#22) ☐ Perceived contribution of "brand name" drug manufacturers vs. generic drug manufacturers to health of Canadians (#67) ☐ Support for additional payment to consume "brand name" prescription drugs (#68) ☐ Preferences among health care options to reduce deficit (i.e., provide more out-patient services; user fees per doctor/hospital visit; decentralize health care — more local clinics/home care, less hospital beds; closing some hospitals; better management; promote preventative medicine) (#73) ☐ Estimated frequency of over-use of public health care system (#74) ☐ Interest in a "living will" (#75) ☐ Support for "right to die" (#76) ☐ Support for assisted suicide (#77) ☐ Support for increasing efforts to better manage pain and ensure quality of life for terminally ill (#78)
	☐ Socio-demos (age; marital status; length of status; place of birth; languages; ethnicity; wartime service; adequacy of income; debts; sources of income; main source; income range) Employment ☐ Employed ☐ Number of weeks worked ☐ Full-/part-time ☐ Activities engage in; main activity (e.g., working for pay or profit; managing a home or being a home-maker; taking care of a family/friends; volunteer) (A12, A13)

Baseline Data Base	Indicators
	Retirement/pre-retirement ☐ age when retired/age expect to retire; voluntary/mandatory retirement ☐ reasons for retiring ☐ spouse/partner influencing retirement ☐ preparations for retirement; (i.e., change work pattern; develop physical activities; hobbies; gather retirement information; contribute to an RRSP; build up savings; invest; pay-off/avoid debts; make major purchases) ☐ length of time spent preparing for retirement ☐ will income be adequate at retirement ☐ are adequate preparations being made for retirement ☐ pension plan through employment ☐ get a job after retirement; job descriptions Activities ☐ Activity level compared to other people of similar age (more, as active, less) ☐ Adequacy of physical activity (too much, little, right amount) ☐ Perception of impact of physical activity on health as one ages, on remaining independent as one ages ☐ Future activity level (more, as active, less) ☐ Leisure activities in a typical month (e.g., radio, chat, arts/crafts, read, have family over) ☐ Activities outside home (e.g., visit; shop (exclude groceries); go to movies; eat out; go for drive; walk, clubs/church, library, card games) ☐ Attend: sporting events, concerts, museums/galleries Health ☐ Health status; relative status ☐ Stresses (i.e., changed/lost job; changed residence, person move in/leave home; death; serious illness/injury, family/friend seriously ill/injured) ☐ Extent of stress ☐ Coping strategies ☐ Health habits (i.e., balanced diet, rest; physically active, brush teeth; avoid smoking/alcohol/drugs) ☐ Activity limitations due to long-term illness/physical condition (#63) ☐ places where activities are limited; coping with limitations; activities which require assistance ☐ electronic devices; ☐ health care features at home (i.e., bathroom modifications; extra handrails; street level entrance, CC TV) ☐ Emotional states in the past few weeks (e.g., on top of the world, depressed, bored; restless; upset; pleased)

Baseline Data Base	Indicators
	Social Support ☐ type of assistance provided to others; relationship of person receiving assistance ☐ type of assistance received from others; relationship of person giving assistance ☐ family composition; relatives; friends ☐ location of relative/friend feel closest to ☐ satisfaction with frequency of contact with family members/friends ☐ pets Dwelling characteristics/Accident and Safety ☐ Need for repair; major/minor repairs ☐ Own/rent; mortgage remaining; market value; other property ☐ Moved in the past five years; reasons for move ☐ Electronic devices in home (i.e., microwave; cable; pay tv; vcr; computer) ☐ Do you feel safe; does this concern limit your activities ☐ Injury in an accident at home in the past 12 months; type of injury; where/when (time/season); product/equipment contributed; treatment ☐ Injury in an accident away from home in the past 12 months; type of injury; when (time/season); treatment Transportation and Travel ☐ Drivers license ☐ Lease/own car/truck; driver or passenger ☐ Frequency drive ☐ Availability of public transportation; public transportation use; ability to use ☐ Trips (i.e., one day; four weeks or more; location; months away)

It is important to stress at this point that the files reviewed for this First Interim Report are only those pertaining to Seniors Community Funding Program projects. Project files from SIRP, NACA and internal activities will be reviewed and the findings incorporated into the Second Interim Report. As Table 1.2 indicates, not all Seniors Community Funding Program project files have been received. Regional staff were unable to locate one of the New Horizons project files and two Ventures project files and two SIP project files have never been received. Three outstanding New Horizons: Partners in Aging project files and one SIP project file were received too late to be incorporated into the file review for these programs and so will not be reviewed.

TABLE 1.2
Distribution of Projects

	1991-92	1992-93	1993-94	1994-95	1995-96	Overall (91-96)
Seniors Community Programs Funding						
New Horizons: Partners in Aging (n=143)						
Sampled	-	-	-	-	45	45
Received	-	-	-	-	42	42
New Horizons (n=4,506)						
Sampled	20	20	45	45	-	130
Received	20	19	45	45	-	129
Seniors Independence Program (n=273)						
Sampled	10	10	30	20	-	70
Received	10	9	30	18	-	67
Ventures in Independence Program (n=29)						
Sampled	-	-	10	10	-	20
Received	-	-	10	8	-	18

The sampling distribution was not based on any kind of proportionate strategy as that would have resulted in an unbalanced set of numbers for drawing conclusions. For example, if a proportionate strategy had been used, of the 350 project files reviewed, 297 would have had to come from New Horizons, nine from New Horizons: Partners in Aging (NH:PA), 18 from Seniors Independence Program (SIP), two from Ventures, six from NACA, eight from SIRP and ten from internal projects. This means that for the majority of programs (in fact, for all but New Horizons) there would not have been enough of a critical mass to analyze or draw conclusions. Rather, numbers were chosen to allow a sufficient mass within each cell as well as to place the bulk of the projects within the New Horizons category as this is where they are most numerous. This breakdown will allow us to speak in general terms about each of the individual types of projects. Community funded projects were also sampled to provide a representative sample of all the provinces/territories. Additionally, community funded projects were sampled based on whether they were ongoing or completed and based on their funding level (e.g., whether they fell in the top half or bottom half of funding amounts received). While for other community funded projects funding levels were divided in half, funding levels were divided into thirds for New Horizons and New Horizons: Partners in Aging.

Detailed information on the data collection process is presented in Chapter Five.

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CHAPTER

2

CONTEXT

2.1 Current Situation of Seniors in
Canada

(a) Demographics

Every year there are more and more seniors in our society, in terms of numbers and proportions. According to Statistics Canada, the population aged over 65 years old represented 12 per cent of the Canadian population in 1991. As shown in Table 2.1, this proportion is expected to grow to 13 per cent between 1991 and 2001 and to 14 per cent by 2011. Statistics show that Canadians aged between 45 and 65 years old will also be more numerous by 2011 than today. Accordingly, those younger than 45 will lose ground in their proportion of the Canadian population, representing 58 per cent of the population in 2011 compared to 69 per cent in 1991.

TABLE 2.1
Demographics

	Population 1991		Projected Population 1991-2001			Projected Population 2001-2011		
	(000's)	Proportion	(000's)	Proportion	Percentage Growth	(000's)	Proportion	Percentage Growth
All ages	26961	100%	30466	100%	13%	33513	100%	10%
< 45	18523	69%	19328	63%	4%	19367	58%	0.2%
45-65	5295	20%	7209	24%	36%	9313	28%	29%
65 +	3143	12%	3929	13%	25%	4832	14%	23%

Source: Statistics Canada, Ageing and Independence, 1991.

This trend is not new and not unique in history. Epidemics, famine, wars and other social factors have periodically modified the age structure of societies. The present trend in Canadian society started many decades ago. Past surveys show that the number of seniors has almost tripled between 1951 and 1991 (Desjardins, 1993). As indicated earlier, this tendency will continue well beyond the turn of the next century and projections suggest that by 2036, seniors could double their current share of the population. In 1951, the 65 and over age group represented 7.8 per cent of the Canadian population. It is projected that by 2036, 23.2 per cent of the population will be over 65 years old. There is also an "ageing of the aged" since the population aged over 75 years is gaining ground among seniors: persons over 75 will constitute about half of the senior population in 2036, whereas 40 years ago they did not quite account for one-third.

Aging of the population is a worldwide phenomena, as shown in Table 2.2. Globally, it is projected that the proportion of the population that is over 65 will rise from 6.2 per cent to 9.7 per cent between 1990 and 2025. Declining fertility — especially in the developed nations — and advances in the areas of transportation, hygiene, sanitation and medicine are the major reasons for this worldwide tendency (Baker, 1988). Generally, this progression will be observable both in developed nations

and in less developed nations. Seniors are proportionally more numerous in the first group (1990), as indicated in Table 2.2, and these differences will maintain themselves over the next few decades. Numeric differences between nations, however, will mean that about 70 per cent of seniors will be living in the less developed nations in 2025.

TABLE 2.2
Estimated percentages of populations aged 65 years and over

Regions	1950	1990	2025
World	5.1	6.2	9.7
Most developed nations (1)	7.6	12.1	19.0
Less developed nations	3.8	4.5	8.0

(1) Most developed nations include North America, Japan, Europe, USSR, Australia and New Zealand.

Source: Desjardins, B., *Population Ageing and the Elderly*, Statistics Canada, 1993, 128 p..

This aging trend will no doubt have great impacts on national economies and on social and health care systems in the future. There are, however, notable differences between industrialised nations regarding aging; because of mass immigration and the important rural population in the Canada (where the fertility rate is generally higher), the aging process has been slower in Canada than in many industrialized countries, including France, the United Kingdom and Sweden⁴. Within Canada, there are also disparities between the Aboriginal and non-Aboriginal populations; the aging trend is observable in both groups but to a lesser extent in the Aboriginal population. The life expectancy is, however, much lower within the second group: currently, life expectancy at birth for Aboriginal women is 73 — compared to 81 for non-Aboriginal females — and 65 for Aboriginal men, compared to 74 for non-Aboriginal males (Department of Indian Affairs and Northern Development (DIAND),

4. *Info-Age*, Vol. 1, No. 1.

1989). Accordingly, only four per cent of the Aboriginal population were over 65, compared to 10 per cent for the total Canadian population, which means that less than one per cent of the total senior population in Canada are Aboriginal seniors.

In Canada, U.S. and other developed countries, immigration and internal migration have led to regional pockets of seniors. A disproportionate number of seniors live in small rural towns, because many young adults leave to work in urban areas (Baker, 1988). Provincial/territorial differences may also be noted in Canada, where the proportion of seniors varies from 14.1 per cent in Saskatchewan to three per cent in the Northwest Territories (Table 2.3).

TABLE 2.3
Seniors Population in Canadian Provinces/Territories

Province/Territory	Percentage of 65+ Age Group of Total Population
Northwest Territories	3.0
Yukon	4.0
Alberta	9.0
Newfoundland	9.7
Quebec	11.1
Ontario	11.7
New Brunswick	12.2
Nova Scotia	12.6
British Columbia	12.9
P.E.I.	13.2
Manitoba	13.4
Saskatchewan	14.1

Source: Statistics Canada, 1991 Census.

In Canada, the life expectancy of females is higher than males. According to the 1991 census, there are seven males for 10 females in the senior population (aged over 64 years) and the gap widens in the older age groups. There also are proportionally more married senior men than women. In 1991, among seniors, more than three males in four had a spouse, while less than one in two females did. One senior male in ten was a widower; one senior female in two was a widow (Table 2.4).

TABLE 2.4
Marital Status

	Married	Widowed	Other (Single, Separated, Divorced)
45+			
Total	71%	15%	14%
Men	83%	5%	12%
Women	62%	23%	15%
45-64			
Total	79%	6%	15%
Men	85%	2%	13%
Women	74%	9%	17%
65+			
Total	58%	31%	11%
Men	78%	11%	11%
Women	42%	46%	12%
80+			
Total	36%	52%	12%
Men	68%	23%	9%
Women	18%	68%	14%

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

(b) Economic Situation of Canadian Seniors

Before the 20th century, seniors mainly relied on their family, church, benevolent societies and personal savings for income once their working years ended (Baker, 1988). This situation has evolved considerably with industrialization (and post-industrialization) and the development of the welfare state.

The public pension system now provides financial independence to most seniors but statistics indicate that the poverty rate among seniors is still higher than in other age groups. According to calculations done by the Canadian Council on Social Development on data from the 1991 census (Table 2.5), 19 per cent of seniors population live below the poverty line (i.e., low income cut-off), a rate higher than the average for the total population (16 per cent). The same source indicates that the poverty rate is higher for unattached individuals of all age groups and again, this is especially true for seniors: 41 per cent of unattached seniors live below the poverty line, compared to 35 per cent of those aged less than 65 years.

Although the poverty rate remains high in this population, national statistics still show that the economic situation of seniors has progressed significantly over the years. Between 1980 and 1990, the percentage of senior couples with incomes below the low-income cutoff (poverty line) decreased from 13 per cent to four per cent⁵. The same source indicates that the percentage of unattached senior men below the poverty line has dropped from 53 per cent to 26 per cent and from 60 per cent to 38 per cent among unattached senior women.

5. National Advisory Council on Aging, *Aging vignettes*, 1993.

TABLE 2.5
Poverty Statistics

	Total (Thousands)	Poor (Thousands)	Dist. of Poor in Total Population	Poverty Rate*
Unattached Individuals — By Age				
Under 65 years	2,400	830	70%	35%
65+ years	880	360	30%	41%
Total	3,300	1,200	100%	36%
All Persons By Age				
Under 15	5,500	1,000	24%	18%
15-34	8,500	1,400	34%	17%
35-64	9,500	1,200	29%	13%
65+	2,900	540	13%	19%
Total	26,000	4,200	100%	16%

Source: Special Tabulations — 1991 Census. Calculations by the Centre for International Statistics at the CCSD.

* Represents the proportion of the poor who belong to this group.

These numbers also indicate, however, that the economic situation varies according to sex. Income of males and females of all age groups over 45 differ significantly according to Statistics Canada (Table 2.6). As shown, more senior men (59 per cent) earn more than \$20,000 a year than women (40 per cent). This is mostly explained by past professional occupations of each sex. As stated by Baker (1988), poverty in old age for women is often the result of a lifetime of discriminatory treatment or lower status. In other words, inequitable distribution of personal savings and of private and public pensions probably account for most of these differences; but as indicated in Table 2.7, more senior men also work full-time or part-time than do women, which is another probable explanatory factor for these differences.

TABLE 2.6
Household and Personal Income

	< \$10,000	\$10,000-\$19,999	\$20,000-\$39,999	\$40,000 +
45+				
Total	9%	22%	30%	39%
Men	6%	19%	30%	45%
Women	12%	24%	31%	33%
45-64				
Total	7%	14%	28%	51%
Men	6%	12%	26%	56%
Women	8%	15%	31%	46%
65+				
Total	14%	38%	34%	14%
Men	7%	34%	40%	19%
Women	19%	41%	30%	10%
80+				
Total	22%	38%	27%	9%
Men	15%	34%	37%	12%
Women	27%	41%	21%	7%

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

TABLE 2.7
Labour Force Activity

	Full-Time	Part-Time	Not Active
45+			
Total	36%	7%	58%
Men	49%	4%	47%
Women	24%	9%	67%
45-64			
Total	53%	9%	37%
Men	69%	4%	27%
Women	37%	14%	51%
65+			
Total	3%	3%	94%
Men	6%	4%	90%
Women	1%	2%	97%

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

Finally, according to NACA, there is also evidence that many Native and Metis elders are extremely economically and environmentally disadvantaged compared to other senior groups (NACA, 1989). Elsewhere, Frideres (1994) writes that most Native people can be characterized as part of the "underclass" of Canadian society; regarding seniors, Frideres notes that fewer Aboriginal elders have formally participated in the wage labour force and as result, many are totally dependent on government assistance for their livelihood.

(c) *Health and Safety*

Health is a major issue in studies on seniors. A recent survey by Synergistics Consulting⁶ suggests that up to 85 per cent of seniors have had at least one "serious" health problem over the last year. Four seniors out of ten reported that their problem is recurrent.

Different sources provide information about the nature of these illnesses. The Synergistics Consulting survey indicates that heart-related illnesses and joint and limb problems are the most common conditions among seniors (Table 2.8). This confirms findings from a previous study (1985)⁷ that found that 63 per cent of senior women and 46 per cent of men suffer from arthritis, rheumatism or bursitis. According to this source, limb and joint problems, cardiovascular diseases and cancer are also the most reported causes of hospitalization. Institutionalization, however, seems to be related to chronic conditions such as Alzheimer's disease and other dementia, incontinence and the effects of stroke, since they are much more common

6. The annual *Elder Monitor* survey conducted by Synergistics Consulting, 1996.

7. Data cited in Desjardins, B., *Population Ageing and the Elderly*, Statistics Canada, 1993, p. 92.

among senior residents of long-term health care institutions than among those living in households (Tully and Mohl, 1995).

TABLE 2.8
Presence of Diagnosed Conditions

Diagnosed Condition	Heart	Arth	Skeletal	Joint	Diabetes	Lung Disorder	Cancer	Other	None
50+	31%	26%	18%	9%	8%	7%	5%	18%	25%
50-64	23%	20%	17%	8%	6%	6%	3%	18%	33%
65+	40%	32%	20%	10%	11%	8%	8%	17%	17%
80+	42%	34%	16%	6%	19%	10%	6%	25%	16%

Source: Synergistics Consulting, Elder Monitor, 1996.

Some authors, however, suggest that these statistics will significantly change over time: Baker cites a longitudinal study published in 1987⁸ that tends to show that non-lethal causes of disability such as arthritis, rheumatism and mental disability will continue, but causes of death such as cardiovascular disease may be subject to control. Documents from NACA confirm this tendency: according to a study cited by the Council, coronary heart disease declined 30 per cent for senior males and 35 per cent for senior females between 1971 and 1986⁹.

This last source also indicates that the physical or mental disability rate was 47 per cent for senior women and 44 per cent for senior men in 1987. In general, the proportion of disability-free life expectancy (average number of years one could expect to live without disability) decreases steadily with age (Desjardins, 1993). In

8. Simmons-Tropea, D., Osborn, R., "Diseases, Survival and Death: the Health Status of Canada's Elderly," in *Aging in Canada; Social Perspective*, Edited by V. Marshall, pp. 520-537. 1987, cited in M. Baker, *Op. Cit.*

9. National Advisory Council on Aging, *Aging vignettes*, 1993.

1986, it was estimated that at 65, one could expect to live 8.8 incapacity-free years (8.1 for men and 9.4 for women). Regarding mental health, Health and Welfare Canada publications cited by NACA estimate that the rate of dementia among seniors was six per cent in 1991. Between 30 and 40 per cent of seniors living in long-term care facilities have a moderately severe dementing illness. It is interesting to note that most gerontologists agree, however, that aging does not always mean decline; many seniors can preserve and enhance their intellectual capacity through mental exercise. Research by Warner Schaie, director of the Pennsylvania State University's Gerontology Center, indicates that people in their 70s or 80s can sharpen their mental skills through mental exercises (Addleman, 1995).

Many texts indicate that the general health of Aboriginal seniors is below average. A survey conducted in Saskatchewan in 1987 indicates that the number of Aboriginal seniors who rate their health as either "fair" or "poor" is 20 per cent higher than for the general senior Canadian population (cited in Frideres, 1994). As mentioned before, life expectancy is much lower among the Aboriginal population; Armstrong-Esther (1994) explains that most of today's Aboriginal seniors have experienced unhealthy living conditions for most of their lives. Poor diet, inadequate housing, alcohol and tobacco use, familial instability and lack of awareness of or access to health services are among the causes of this situation. Even though there can be significant differences between Aboriginal groups, studies in Alberta and Saskatchewan cited by the author indicate that there are high rates of degenerative diseases among Aboriginal populations. For example, the prevalence of diabetes is four times higher among Aboriginal seniors than in the general population. There also are high prevalence rates of back, heart, blood pressure, dental and vision problems among Aboriginal seniors.

Accidents, Injuries and Hospitalization

Statistics indicate that young people are most likely to suffer from injuries and in general, injury rates decline with age¹⁰. Nevertheless, accidental injury is one of the leading causes of death and hospitalization among seniors. Falls are a common cause of accidental injuries and most occur in the home. For those aged 65 and older, hip fractures are the leading cause of hospitalization following accidental falls. The most common causes of falls in this age group are poor balance and weak muscular coordination, the use of psychoactive medication, and environmental hazards. Seniors psychoactive medications such as sedatives, antidepressants, and antipsychotics have been found to increase the likelihood of falling about 300 per cent. The most common causes of falls are missing steps and tripping on uneven surfaces¹¹.

Because of these injuries and illnesses in general, seniors remain the age group requiring the most medical assistance. Since the prevalence of chronic conditions increases with age, the frequency of consulting physicians is greatest at older ages. For example, 72 per cent of 15 to 19 year olds consulted a physician at least once in the previous year, compared to 89 per cent of those aged 75 and over¹². A minority of very old people, however, are using the majority of health resources (Baker, 1988). Seniors in general spend more nights in health care institutions according to the General Social Survey (1991). In 1990, 17 per cent of seniors over 65 spent at least one night at the hospital (19 per cent for men and 15 per cent for

10. Statistics Canada, Health Statistics Division, *National Population Health Survey Overview*, 1994-95.

11. Statistics Canada, Health reports 1992, Vol. 4, No. 4, p. 352.

12. Statistics Canada, Health Statistics Division, *National Population Health Survey Overview* 1994-95, p. 14.

women) compared to 11 per cent for the population aged over 15 (Table 2.9). Data also show that this increases with age and that more seniors spend three nights or more a year in health care institutions than do younger adults.

TABLE 2.9
Number of Institutionalized Nights in 12 Months
Preceding Survey by Sex and Age Group
Canada, 1991

Sex and Age Group	Total Population 15+		No Nights		Total with Nights		1-2 Nights		3+ Nights	
	No.	%	No.	%	No.	%	No.	%	No.	%
Both Sexes										
Population 15+	20,981	100	18,678	89	2,290	11	614	3	1,617	8
65+ years	2,908	100	2,403	83	499	17	89	3	399	14
65-74 years	1,824	100	1,555	85	264	14	51	3	208	11
75+ years	1,084	100	847	78	235	22	38	4	191	18
Male										
Population 15+	10,266	100	9,363	91	899	9	294	3	599	6
65+ years	1,245	100	1,001	80	241	19	49	4	189	15
Female										
Population 15+	10,715	100	9,315	87	1,391	13	321	3	1,018	9
65+ years	1,664	100	1,401	84	258	15	39	2	210	13

Source: Statistics Canada, General Social Survey, 1991.

Other statistics indicate the nature of the causes of hospitalization among seniors. As shown in Table 2.10, diseases of the circulatory system are the most

common causes of hospitalization (in terms of frequency of visits), especially among men. Data from this source also indicate that senior men are much more subject to hospitalization because of cancer, genitourinary, respiratory or digestive diseases than senior women, while the latter go to hospitals more often for musculoskeletal diseases than do senior men. In general, men go to hospitals more often than women but in terms of duration, senior women tend to stay in hospitals longer (see Table 2.10).

In global terms, these statistics (Table 2.10) also suggest that health service utilization not only rises dramatically with age but also changes in nature: cancer for example, represents 9.6 per cent of the causes of hospitalization for men aged between 45 and 64, but accounts for 12.6 per cent for those aged over 65. As well, diseases of the respiratory system represents 6.2 per cent of all cases of hospitalization for men aged between 45 and 64, but account for 10.5 per cent of hospitalization for those aged over 65. The proportion of certain causes of hospitalization also changes with age for women. Hospitalization for diseases of the circulatory system progresses sharply with age for women: while they represent 12.9 per cent of all causes of hospitalization for women aged between 45-64 years, they account for 23.6 per cent for women aged over 65. These statistics therefore suggest that health service utilization not only increases with age but also changes in nature.

TABLE 2.10
Separation Rate¹ for Persons Aged 45 and Over
by Cause of Hospitalization, Broad Age
Group and Sex, Canada, Fiscal Year 1987-1988

Causes of hospitalization	Males			Females		
	45-64 years	65-74 years	75 years and over	45-64 years	65-74 years	75 years and over
Neoplasms	1,532	4,567	6,824	1,944	3,040	3,368
Diseases of the nervous system and sense organs	697	1,934	3,670	725	2,088	3,978
Diseases of the circulatory system	3,753	8,785	14,065	1,865	5,294	11,101
Diseases of the respiratory system	981	3,004	6,497	846	1,817	3,258
Diseases of the digestive system	2,512	4,140	5,966	2,022	3,034	4,623
Diseases of the genitourinary system	1,221	3,412	4,841	1,766	1,568	1,622
Diseases of the musculoskeletal system	1,106	1,425	1,619	1,196	1,907	2,262
All causes	15,940	34,125	56,342	14,356	25,528	43,662
Average length of stay (in days)	11.0	15.8	24.6	11.4	17.1	33.4

Source: Statistics Canada, Hospital Statistics, cited in Desjardins (1993).

¹ Separation rate: the number of hospital separations during a given year divided by the average population for the year (per 100,000).

Crime and Safety

Crime and safety is an important issue for seniors and seniors organizations. Although there were some fluctuations, statistics generally show that between 1962 and the mid 70s, the homicide rate increased for all age groups. Between the mid 70s and 1991, the homicide rate generally declined for all age groups,

and were consistently lower for seniors than for younger individuals (Trevethan, 1992). An analysis of data from 13 police departments shows that three per cent of violent crime victims were 60 years of age and older, considerably less than their proportion in the 1991 Canadian population (16 per cent). Previous research shows, however, that although seniors are victims of violent crime less often than other age groups, they tend to express higher levels of fear of such victimization and report crime more often (Trevethan, 1992). According to results from the Elder Monitor led by Synergistics Consulting in 1995, 17 per cent of seniors aged over 65 are somewhat often to very often afraid for their physical safety/security due to conditions in their immediate community (Table 2.11).

TABLE 2.11
Frequency Been Afraid for Physical Safety/Security
Due to Conditions in Immediate Community

	Very Often	Somewhat Often	Not Very Often	Never
50+	6%	8%	30%	56%
50-64	4%	7%	32%	57%
65+	8%	9%	27%	56%
80+	3%	3%	20%	73%

Source: Synergistics Consulting, Elder Monitor, 1996.

(d) Independence

In very general terms, personal independence may be defined as a situation where an individual has the capacity to undertake activities without the assistance or interference of other actors or institutions. Accordingly, institutional placement has been criticized for increasing dependency and restricting individual

autonomy and choice (Gee and McDaniel, 1993). Baker cites a study that suggests that seniors living at home express greater life satisfaction than those in institutions (1988: 50). Other studies also indicate that most seniors in Canada, the U.S. and the United Kingdom prefer remaining at home as long as possible¹³. Considering these results, living circumstances may be considered an important indicator of the level of independence of today's seniors.

According to Statistics Canada, few seniors (8.5 per cent) lived in collective households in 1991 (Desjardins, 1993). The author notes that most of these are institutional residents. Another source (Tully and Mohl, 1995) indicates that five per cent of Canadians aged over 65 were living in long-term health care institutions in 1995 and 18 per cent of seniors aged 80 or over lived in long term institutions. The situation has, however, evolved during the 80s: according to data from Statistics Canada cited in NACA documents, the percentage of seniors living in institutions actually decreased between 1981 and 1991¹⁴. Numbers cited in this source suggest that the younger seniors are living independently longer: between 1981 and 1991, the percentage of institutional residents aged over 74 (i.e., the older seniors) rose from 82 per cent to 85 per cent, while the percentage of seniors living in institutions overall decreased from eight per cent to 6.4 per cent.

More than half of seniors live in a family situation, almost always as part of a couple (Desjardins, 1992); another Statistics Canada source corroborates this (Table 2.12) but also shows that among those not living in institutions, proportionately more seniors aged 80 and over live alone than their younger counterparts.

13. For example, Walker, A. "The Relationship Between the Family and the State in the Care of Older People" in *Canadian Journal of Aging*, Vol. 10, No. 2, 1991, 94-112; Addleman R. B., "Eldercare: Out of the Institution and into the Community" in *Healthcare Forum Journal*, May/June 1995, pp. 58-63.
14. National Advisory Council on Aging, *Aging Vignettes*, 1993.

Table 2.12 also shows the significant differences between senior men and women regarding living circumstances. As indicated, a greater proportion of men than women live in collective households while more women live alone. Differences are also found in terms of residents of institutions: 73 per cent of those living in long-term institutions were women (Tully and Mohl, 1995). In most cases, this can be explained by the fact that women tend to outlive their mates and according to Desjardins, data from the census suggests "that the survivor of an aged couple lives alone as long as possible after the spouse's death before moving into an institution. Since men lose their spouses less often and later in life, the life profile of men and women is different. Around age 75, more women live alone than in a family, a phenomenon not encountered at any age among men" (1993:62).

TABLE 2.12
Household Size

	1 Person	2 People	3 People	4 + People
45+				
Total	19%	44%	18%	19%
Men	11%	46%	20%	23%
Women	25%	43%	16%	16%
45-64				
Total	11%	39%	23%	27%
Men	9%	36%	24%	31%
Women	14%	42%	22%	23%
65+				
Total	31%	54%	9%	6%
Men	16%	67%	11%	6%
Women	43%	45%	7%	6%
80+				
Total	46%	41%	6%	7%
Men	23%	63%	8%	7%
Women	59%	28%	5%	7%

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

Note: Data does not include institution residents.

Finally, it should be mentioned that according to studies cited by NACA, 91 per cent of retired seniors report that they do not experience housing problems (1990)¹⁵. This information and other available data therefore suggests that most seniors remain relatively independent from this point of view: a minority of seniors live in institutions and most do not experience problems regarding housing. Of course, one must be careful; as Desjardins suggests, statistics give the impression of the presence of a combined will *and capacity* to remain autonomous, but other numbers, such as those describing the financial situation of seniors, tell another story. Income may be considered another important indicator of independence and as mentioned earlier, although many may live in their own household, many seniors still live with limited income.

The level of independence of today's seniors may also be analyzed in terms of activities. As shown in Table 2.13, about half of seniors take walks — the single most important activity outside the home — on a regular basis (35 per cent among those aged over 80). In most cases, these statistics tend to show that seniors remain fairly active, compared to those aged between 45 and 64 years. Apparently, more seniors do activities related to games or activities situated at church, clubs or community centres, than those aged between 45 and 64. The second group, however, tends to eat out more frequently and visit friends and relatives more often.

Transportation

Means of transportation may also be considered an important factor and indicator of seniors' independence. Data cited by NACA indicates that 87 per cent of

15. National Advisory Council on Aging, *Aging Vignettes*, 1993.

senior couples own a car¹⁶. There are, however, significant differences between men and women. According to a Statistics Canada survey, 80 per cent of senior men have a drivers licence, compared to only 37 per cent of women¹⁷. According to the same source, senior men also drive more frequently than senior women.

Fewer senior singles own a car and here again, there are significant differences between men and women. Data from NACA indicates that 63 per cent of unattached senior men own a car, compared to 33 per cent of unattached senior women¹⁸. Most seniors use public transportation. According to the same source, the likelihood of using public transportation is 67 per cent for senior couples, 65 per cent for unattached men and 78 per cent for unattached women (1986 data). It must be noted, however, that this can be a problem for small-town seniors. NACA documents report that between 25 per cent and 30 per cent of small town seniors do not drive a car and very few small towns have collective transportation services such as buses or taxis (1990).

16. Ibidem.

17. Statistics Canada, *Ageing and Independence; overview of a national survey*, 1993, p. 28.

18. National Advisory Council on Aging, *Aging Vignettes*, 1993.

TABLE 2.13
Activities Outside the Home¹

	Visit Friends/ Relatives	Shopping (exclude groceries)	Eat Out	Go for a Drive	Walk	Clubs/ Church	Library	Cards/ Games
45+								
Total	37%	26%	23%	29%	50%	34%	11%	21%
Men	32%	30%	24%	31%	48%	30%	8%	19%
Women	40%	31%	23%	28%	53%	37%	13%	23%
45-64								
Total	38%	25%	25%	30%	51%	31%	10%	19%
Men	33%	18%	27%	30%	46%	27%	7%	16%
Women	43%	31%	24%	29%	57%	34%	13%	21%
65+								
Total	34%	28%	20%	27%	49%	39%	11%	26%
Men	31%	23%	19%	31%	52%	36%	10%	25%
Women	36%	32%	21%	24%	46%	42%	12%	27%
80+								
Total	24%	24%	18%	19%	35%	36%	*	22%
Men	25%	23%	14%	23%	41%	37%		25%
Women	23%	24%	19%	17%	32%	35%		21%

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

- ¹ Activities respondents reported doing "often" in a typical month.
* insufficient sample size

Thus, senior independence is relative and varies considerably from one sex to another and from one region to another. It also depends on the level and type of support the seniors may receive from formal and informal sources.

(e) Informal and Formal Support

Many seniors rely on family, friends and professionals to meet their day-to-day needs. These support mechanisms may be divided into two groups: formal support through institutions, clinics and professionals; and informal support ensured by family and friends.

As Marshall (1993) points out, when seniors become ill, they are likely to attempt first to care for themselves. If unable to do so, they are likely to seek care or help *informally*, such that, up to 75 per cent of care received by community dwelling seniors is provided by family, friends and neighbours rather than by formal care providers. A recent survey also indicates that 58 per cent of seniors (65 years and older) prefer relying on people they know to get help, while 22 per cent preferred relying on agencies¹⁹. A study in Britain shows that seeking formal help is only the final stage of a dynamic process in which the available sources of informal assistance have all been considered, and the costs associated with them evaluated, *before* any approach is made in statutory services for assistance (Walker, 1991).

Informal Care

Most seniors receive some help with at least one activity, including grocery shopping, housework, meal preparation, yard work, managing money, and personal care, for example. Of course, most people of all ages call upon others for assistance from time to time but as Table 2.14 indicates, assistance tends to increase with age. As shown, 57 per cent of people aged between 45 and 64 of this sample reported receiving some assistance and this percentage rises to 73 per cent for those aged 80 or more.

19. The annual *Elder Monitor* survey conducted by Synergistics Consulting, 1996.

TABLE 2.14
Assistance

	% Receiving Assistance	Type of Assistance Received			
		Housework	Meals	Transportation	Emotional Support
45+					
Total	58%	35%	30%	30%	35%
Men	55%	37%	37%	22%	31%
Women	62%	33%	23%	36%	39%
45-64					
Total	57%	35%	32%	27%	38%
Men	54%	38%	38%	23%	33%
Women	59%	32%	26%	32%	42%
65+					
Total	61%	36%	26%	33%	30%
Men	56%	37%	34%	20%	26%
Women	66%	35%	20%	43%	33%
80+					
Total	73%	50%	33%	49%	33%
Men	70%	49%	39%	34%	29%
Women	75%	51%	29%	57%	25%

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

Many studies in Canada and abroad show that caregivers are most often women, especially wives and daughters²⁰. As Walker points out, there is a feeling of obligation to take care of older parents. His work in Britain shows that "even children who had, for example, received little other than abuse from a violent and alcoholic parent, still felt an obligation to help or expressed guilt at their failure to do so" (1991: 100).

Table 2.15 indicates the source of care to Canadian seniors, according to a 1991 study. As indicated, a spouse/partner (44 per cent) is the primary source, followed by daughters (34 per cent).

20. See A. Walker (1991), Gee, E.M. and S. McDaniel (1993), M. H. Smith and C. F. Longino (1994), etc..

TABLE 2.15
Assistance Provider

	Spouse/ Partner	Daughter	Son	Friends/ Neighbours	Grandchildren	Volunteer Groups	Paid Help
45+							
Total	61%	36%	33%	33%	8%	7%	5%
Men	75%	30%	33%	29%	5%	6%	4%
Women	50%	42%	34%	35%	10%	8%	6%
45-64							
Total	71%	38%	37%	34%	5%	6%	*
Men	79%	31%	36%	31%	*	5%	
Women	63%	43%	38%	38%	7%	6%	
65+							
Total	44%	34%	27%	29%	12%	9%	9%
Men	65%	24%	26%	26%	9%	7%	8%
Women	30%	40%	28%	31%	14%	10%	10%
80+							
Total	24%	37%	29%	31%	16%	12%	16%
Men	*	*	*	*	*	*	*
Women	*	*	*	*	*	*	*

Source: Statistics Canada, Survey on Ageing and Independence, 1991.

* insufficient sample size

Women in general are more likely to provide informal support and most assume the costs associated with this. These costs can be economical, physical, emotional and/or psychological. According to a recent study, this is especially true for those who take care of seniors who suffer from dementia: seniors who are living in the community and suffer from dementia are more likely to have a caregiver who is a female (75.4 per cent) than are those without dementia (66 per cent)²¹. This research also indicates that six per cent of all informal primary caregivers were employed, thus having a dual role. The authors of this article cite many studies that associate distress, depression and other emotional changes with caring for a senior person with dementia. There is also some evidence that physical health may be

21. "Patterns of Caring for People with Dementia in Canada" in *Canadian Journal on Aging*, Vol. 13, No. 4, 1994, p. 478.

affected by providing care. The study shows that 10 per cent of caregivers report requiring additional services (30 per cent of those caring for someone with dementia); the greatest single demand is for day care (nine per cent of caregivers)²².

Female caregivers in general are exposed to certain health risks and some openly express some need for assistance but as Walker (1991) explains, this sexual division of caregiving help is still, sadly, socially accepted. Women are too often regarded as "natural" caregivers and moreover, their altruism is also portrayed as "natural". Yet research shows that these caregivers often need assistance and if this is not provided, they may end up in need of formal help themselves.

Formal Support

Results from a major study in Manitoba show that there is not a perfect division between formal and informal support. Apparently, many seniors who utilize formal care do so while retaining care from their informal network. Use of the formal system in conjunction with informal care appears to take place in two instances: when seniors are in need of critical elements that their informal network are lacking, or when their health needs are very high. In both these situations, the formal system enters to assist the informal network, but the two systems are complementary (Chappel and Blanford, 1991).

Regarding institutional care, Canada admits a high proportion of its senior population to institutional care compared to other industrial countries; 7.5 per cent of those aged over 65 in 1990, compared to 4.1 per cent in England and 4.5 per

22. "Patterns of Caring for People with Dementia in Canada" in *Canadian Journal on Aging*, Vol. 13, No. 4, 1994, p. 472.

cent in the United States in 1989²³. However, while the health condition is an important determinant of individual institutionalisation (see earlier section on seniors' health), it is not always the sole determinant. Those who receive assistance only from their informal network are younger, are in better health, *and have informal support available, particularly household members*. Those who receive care from both systems tend to have fewer children, fewer neighbours and no household member, that is, their informal network is limited. They are older and have poorer health (Chappel and Blanford, 1991). Family income is also a factor: good health is directly related to a higher family income (Baker, 1988).

Some studies show that female seniors have more extensive informal networks than male seniors and have more support from these sources. They are also more likely than men to receive formal sources of support. However, it seems that men have been receiving more and more of this type of support. One study (Chipperfield, 1994) shows that for women, the sources of support were identical between 1971 and 1983. Men however, received more formal support and less informal support than women in 1983 than in 1971. The author attributes this to a substitution effect, where men either receive formal support or no support at all. Thus, because their personal networks are less developed than their female counterparts, men seemed to have profited more from the development of formal care services that took place during the 70s.

As mentioned earlier, formal support remains much more limited than informal sources. Notwithstanding availability of services, many factors may explain this; Saperstein suggests that low usage of respite care comes from unfamiliarity, costs (at least in the U.S.), concerns over the appropriateness of respite care, guilt and perceived stigma attached to behavioral or psychiatric symptoms, and philosophical values opposed to using respite care. Caregivers often view services as a last resort,

23. Ibidem, p. 471.

rather than a way to prevent or alleviate their own stress²⁴. Also, services are not always available or well known: "senior citizen apartments with nursing and homemaker services often have long waiting lists and many older people are unaware of provincial government home-care programs" (Baker, 1988:67). Results from another study also suggest that the availability of support services for community caregivers varies considerably within and between provinces/territories²⁵.

Future of Demand for Formal and Informal Care

Many specialists have expressed some concern over the future of formal and informal support. The aging trend and the state of today's and tomorrow's public finances does not spring optimism among most observers; the higher proportion of senior citizens and the size of the public debt will probably limit state spending for decades and will undoubtedly have important implications.

Financial factors will surely have an impact on the care of seniors; at this time, the viability of the Canadian pension system of the 21st century is still not ensured and many share pessimistic views on the living conditions of tomorrow's seniors. Public finances are a main variable in this debate but other predictable social factors should also be considered, according to many gerontologists and sociologists.

The future of pensions and formal care is directly dependent on future public spending. Social factors may, however, have more important effects on *informal*

24. Cited in "Patterns of Caring for People with Dementia in Canada" in *Canadian Journal on Aging*, Vol. 13, No. 4, 1994, p. 482.

25. "Patterns of Caring for People with Dementia in Canada" in *Canadian Journal on Aging*, Vol. 13, No. 4, 1994, p. 480.

care: as mentioned in the previous section, most care for seniors comes from informal sources, mainly from female individuals of the senior's family. Trends in demographics, family structure and labour-market participation suggest, however, that this source may also be endangered. A higher proportion of seniors, smaller families — that is, with fewer children who are potential caregivers — and a higher female participation rate in the labour market may limit informal sources of senior care. This leads many specialists²⁶ in the field to say that there will probably be a higher demand for formal care for seniors tomorrow than there is today. These factors and the rising divorce rate may limit the number of caregivers²⁷ and spur demand for formal care and should also be considered by today's and tomorrow's policy makers.

(f) Attitudes

Society's attitudes towards seniors has evolved considerably since the beginning of the Industrial Revolution, according to observers. Many attest that the status of seniors in Western Society has lost ground over the last century or so. According to the literature, before, society relied more on the memory, skills and experience of seniors. Today, we rely less on traditional skills and seniority is not always valued by young educated professionals. In other words, higher education and technological change have made much of seniors knowledge redundant. In a society centered on high-tech such as ours, this tends to lower the status of seniors (Baker,

26. Such as Chipperfield (1994), Gee and McDaniel (1993), Smith and Longino (1994), for example.
27. Thus putting more pressure on those who will assume caregiving responsibilities in the future. Some American observers even go to say that "Granny dumping" at hospital emergency rooms may be the social epidemic of the next century in the U.S.A., as stressed families are unable to cope with parents or relatives living longer than ever. In an informal survey led by the American college of Emergency Physicians, emergency rooms had an average of eight abandonments a week (Addleman R. B., "Eldercare: Out of the Institution and into the Community" in *Healthcare Forum Journal*, May/June 1995, p. 59).

1988). A similar trend seems to be occurring among Canadian Aboriginal populations where seniors are increasingly estranged from their younger peers as a result of extensive social and political change. Movements from a hunting and gathering society to one of social assistance and formal education has considerably modified the role of Aboriginal elders and consequently, the attitudes towards them. Their influence within the Aboriginal community is diminished as their economic, spiritual and other forms of contributions are becoming less and less important (Frideres, 1994).

Perceptions of Seniors

Despite these long-term trends, research indicates that North American seniors generally share positive views of themselves. Participants in focus groups led in Canada by Tandemar Research in 1988 indicated that "typical" seniors feel that seniors enjoy an excellent quality of life. Their mood was generally positive and they felt that the "unfortunate" seniors are the exception. Focus groups led by Optima in 1991 tended to show that many adults over 65 don't consider themselves to be "seniors" (*ainés*). Evidence from the United States (Seccombe and Ishii-Kuntz, 1991) shows, however, that perceptions of aging and seniors' problems vary from one senior age-group to another: middle-aged seniors are generally more pessimistic about different problems regarding aging while the older seniors are more optimistic. According to this study, middle-aged seniors (75-84) tend to report that money, loneliness, housing, fear of crime and jobs are serious problems for seniors. The over 85 group view these problems as less serious as do their younger counterparts (55-84). Single seniors in all age groups, however, were more likely to be pessimistic with respect to the problems that the aged face.

Non-seniors tend to evaluate aging as more problematic than do seniors, according to this same source and other American texts. Publications cited in Seccombe and Ishii-Kuntz' article indicate that many American children, adolescents,

students and adults view seniors as being weak, in poor health, dependent, asexual, socially isolated, unattractive and of low competence. Non-senior participants in the above mentioned focus groups (Tandemar Research, 1988) also talked more about poor health, financial difficulty and loneliness than did the seniors.

Potential for Intergenerational Conflicts

Among other factors, attitudes and policies towards seniors of all ethnic origins are also dependent on the financial costs associated with their condition. As mentioned before, the aging trend has many worried about the future costs of supporting seniors and this has provoked a very passionate debate on how to correct the situation. Some observers are afraid that an intergenerational conflict may emerge between older and younger adults on how to settle this situation, that is, either by increasing today's worker's contributions to pension funds or by decreasing the amount of today's pensions. Conflicts may arise if health and public pension costs are increasing and if population aging is seen as the culprit. As Walker puts it:

Ageing is seen as a problem to the extent that it poses a potential threat to the economic growth and, by implication, social cohesion. It is argued, for example by the OECD, that the working population will not be willing or able to bear the tax levels necessary to fund societal ageing. (Walker, 1990: 387)

In this debate, the principle of intergenerational equity or solidarity is sometimes evoked, an idea that the young and old should have similar access to opportunities, including social policy benefits.

Many authors decry such a trend and for Minkler²⁸ this debate diverts attention from other disparities that cross generations. According to the author, the concept of intergenerational equity is misleading as a basis for policy because it diverts attention from the extent of inequalities *within* age groups and hence the case for *intragenerational* equity. For the author, more probable is the development of fissures in relation to different forms of consumption, that is, between those who rely on public welfare and those who rely on a mix of private and public welfare. Interests of both groups are different and this is likely to divide older people politically more than it will unite them. This conflict will intersect generational cohorts.

In any case, there is no serious evidence of growing intergenerational conflicts in Canada (Gee and McDaniel, 1993) and as many authors point out, sound public policies should prevent this.

2.2 Seniors at Risk

The concept of seniors being "at risk" is the basis upon which many programs for seniors are developed by government, community agencies and service groups (Canadian Association on Gerontology, 1995). The term "seniors at risk", however, is very vague and unless clarified can create the illusion that there is consensus as to its meaning. For the Division of Aging and Seniors (DAS), this term refers to situations in which seniors' health, well-being and independence is threatened. For the DAS, the greatest harms for which seniors could be at risk include major loss in health status, premature death, premature institutionalization and major dependency on others for personal or financial support (*Connections '95*). Of importance is that "at

28. Cited in Walker, A., "The Economic 'Burden' of Ageing and the Prospect of Intergenerational Conflict" in *Ageing and Society* 10, 1990, p. 391.

risk" is not a term that seniors use to identify themselves. Instead it is a term used by others — usually someone other than a senior — to label seniors.

Defining Risks and at Risk Groups

As outlined in the Conceptual Framework on seniors at risk produced by the Canadian Association on Gerontology, situations of risk may include poor health, abuse, advanced age, low income, lack of support and loss or bereavement. Being in one of these situations, however, does not in and of itself guarantee that a senior is "at risk". There are other factors at play that may negate the senior in any one of these situations from being "at risk". Risk is best understood as the relationship between three elements: risk factors; resources; and life experiences. How these three factors interact with each other will affect the extent to which a senior is "at risk".

Risk factors are those elements which identify seniors who are more likely to be at risk than other seniors. There are two types of risk factors: intrinsic or personal; and extrinsic or environmental. Intrinsic risk factors include factors such as age, gender and history. For example, a women over the age of 75 who has a history of falls is more "at risk" of falling than another senior. Extrinsic risk factors include environmental hazards in the seniors home or public places such as scatter rugs, poor lighting or uneven pavement. It is important to remember, however, that no environment is without risk. While these factors may identify certain seniors as being "at risk", it does not guarantee a negative outcome. In other words, while the factors may exist, it does not mean the problem does as the senior's resources and life experiences also play a role.

A senior's personal or social supports, that is, their resources, can counteract the negative effects of risk factors. These resources will help a senior to better cope with their life experiences and maintain their health and well-being. There

are two types of resources: internal and external. Internal resources are the psychological resources that a senior has such as inner strength or adaptive strategies (e.g., taking notes to compensate for short-term memory loss). External resources include social supports as well as economic (e.g., sufficient income) and environmental resources (e.g., technologies to make day-to-day living easier). When the resources available are not enough to meet a senior's needs, then their level of risk will increase.

Risk may also be influenced, either positively or negatively, by a senior's life experiences. Past life experiences may, for example, decrease risk by shaping a senior's personality, adding to their personal resources or affecting the way they view their situation. A senior, for example, who grew up during the "Dirty 30s" may not view their financial situation as negatively as a senior who grew up during more prosperous times. On the other hand, if a senior's life experiences include living in a disadvantaged environment most of their life, then the possibility of risks, such as depression or ill health, may increase due to a higher probability of stressful events occurring, such as being robbed.

This being said and considering the literature discussed earlier, we may still distinguish three social groups that appear to be more "at risk" than others.

As health is directly related to income (Baker, 1988), there is no doubt that seniors with limited income constitute a major segment of seniors at risk. As indicated earlier, up to one senior in five is considered "poor", a proportion that climbs to 41 per cent among those living alone. Statistics show that women constitute an important sub-segment of low-income seniors and of those living alone, which is why they may also be considered a second major at risk group. More than 40 per cent of senior women live alone and fewer women have a driver's licence than do men (37 per cent compared to 80 per cent) or own automobiles (33 per cent vs. 67 per cent, respectively, for unattached women and men). Although they represent less than one

per cent of the population, health statistics still show that Aboriginal seniors are more at risk than non-Aboriginals; as mentioned earlier, for many reasons that are not always economical (such as past lifestyles), the life expectancy of Aboriginal seniors is significantly lower than for non-Aboriginal seniors.

Of course, by distinguishing these three groups as being at risk, one should not exclude individuals from other social groups. Men may also be considered as being more vulnerable to certain health problems (such as cancer and cardiovascular diseases) or at risk because they live in isolated areas where public transportation is limited. Still, the above mentioned groups appear to be more at risk than average and may justify specific interventions on their behalf.

Potential Role of the Federal Government in Reducing Risks

At a conference held in Hull, Quebec (*Connections '95*), the need for all levels of government, local communities and their organizations, service providers and seniors to become involved in addressing the needs of seniors in situations of risk was stressed by the then Director of DAS. In NACA's 1992 publication, *Seniors' Independence: Whose Responsibility*, they argue that it is the responsibility of governments to "provide the necessary framework for independence and facilitate the actions of individuals, families and other community agents" (NACA, 1992: p. 9). The specific responsibilities of governments, as outlined in this document, are as follow:

- ☐ provide seniors with a supportive environment that will facilitate independent living;
- ☐ provide informal caregivers with the necessary support;
- ☐ disseminate information about government programs and services to seniors and their families;

- ☐ make it easier for seniors and their families to access information;
- ☐ support the work being conducted by non-profit organizations for seniors;
- ☐ provide the resources needed to develop gerontology education for service providers;
- ☐ finance and promote scientific research on aging;
- ☐ promote a model that will assist the private sector in implementing policies and promoting the well-being of workers of all ages;
- ☐ ensure that the policies and practices of the workplace reflect the needs of older workers;
- ☐ collaborate with business, consumers, non-profit organizations and industry in the development of a national, multi-sectoral policy framework that incorporates health, financial security, housing and social services; and
- ☐ promote a realistic image of seniors.

Seniors themselves are very much aware of the key role that government programs play in ensuring their health, well-being and independence. In a study by Optima (1991), seniors indicated that government programs such as Canada Pension Plan, Medicare, Pharmacare, medical alert devices, home support services, hospital care and disabled transit services were essential to helping seniors maintain their independence. In this same study, seniors also provided a number of suggestions as to what governments (both federal and provincial/territorial) and communities can do to help seniors maintain their quality of life and independence. These suggestions include:

- ☐ health care alternatives:
 - more community home support options
 - more palliative care units
 - financial help with glasses, dentures and hearing aids
 - easier access to medical support devices;

- ☐ finances:
 - additional financial incentives for home owners
 - guaranteed pensions
 - more flexible retirement policies
 - more paid work opportunities;
- ☐ housing:
 - more affordable housing in community-based locations; and
- ☐ transportation:
 - special transit
 - more flexible scheduling.

While some of these suggestions would require the direct involvement of the federal government (e.g., more flexible retirement policies, guaranteed pensions), for others, federal government involvement could be more in terms of providing financial support to community and seniors organizations through programs such as delivered by the DAS (e.g., funding for community home support options, easier access to medical support devices).

2.3 Comparison of Other "At Risk" Groups

There is no denying that seniors face challenges to their health and well-being as well as to their independence and ability to continue to contribute fully to their communities and society in general. The question, however, is: do these challenges put them any more at risk than other at risk groups? This section will outline the situation of some of the other at risk groups in Canada (namely children, Aboriginals and immigrants/visible minorities), comparing, to the extent possible, their situation to that of seniors. As statistics will be taken from different sources, direct comparisons between groups will not be possible for methodological reasons (e.g., indicator definitions).

(a) Children

Children make up a significant portion of the Canadian population. In 1991, 28 per cent of the Canadian population was aged 19 and under. The percentage of children making up the total population was highest in the Northwest Territories, where children (aged 19 and under) made up 41 per cent of the population (Statistics Canada, 1992). In comparison, seniors comprised 12 per cent of the overall population in 1991.

Economic Situation

One major concern of importance to the health of children is the growing number of children who are living in poverty. Poverty has been demonstrated to be a key determinant of child health having been linked to an increase in a wide range of risks, including school dropout rates, injuries, infant death rates, low birth weights, and mental health, for example (Canadian Institute of Child Health, 1994). As demonstrated in Table 2.16, the number of Canadian children living in poverty had grown to over 1.2 million in 1991. This represents 18 per cent of all children.

TABLE 2.16
Number of Children Living in Poverty, Under 18 Years — Canada

Year	Number of Children in Poverty	Total Number of Children in Canada
1981	763,400	6,845,145
1987	1,067,800	6,549,610*
1991	1,211,900	6,814,140

Source: Canadian Institute of Child Health, *The Health of Canada's Children: A CICH Profile*. 2nd edition, 1994.

* This figure represents the 1986 Census data which is the closest census year to 1987.

While at 19 per cent (Canadian Council on Social Development, 1996) the poverty rate of seniors 65 and older is higher than that of children under the age of 18, the incidence of low income has been on the decline for seniors while it has been on the increase for families with children (NG, 1992). One of the reasons for this is that the primary source of income for seniors is Government transfers (67 per cent of seniors). For children, on the other hand, the primary source of income (for families) comes from employment income. Consequently, the economic situation of children tends to fluctuate with the overall economy. Although the economic situation of seniors has greatly improved, the significant differences in economic security among seniors and the disproportionate number of seniors who are barely over the poverty line should not be ignored (Canadian Association on Gerontology, 1995).

Health and Well-Being

Overall, children between the ages of 10 and 19 consider themselves to be in very good health: 40 per cent of 10 to 14 year olds indicated their health to be very good and 63 per cent of 15 to 19 year olds rated their health as very good to

excellent (Canadian Institute of Child Health, 1994). While seniors also tend to perceive themselves as being in good health (62 per cent indicating their health was good or better), only a small percentage of seniors rated their health as better than good (19 per cent rated their health as excellent). This may be explained in part by the relatively low number of children who have long-term conditions such as arthritis, diabetes, heart disease and lung conditions. Less than one per cent of children 14 years old and younger suffer from any one of these conditions. In comparison, eight per cent of seniors over 65 suffer from lung disorders, 11 per cent suffer from diabetes, 32 per cent suffer from arthritis and 40 per cent suffer from heart disease (as indicated in the previous section). The incidence of cancer for children is also lower than it is for seniors at less than one per cent of children under the age of 19 (Health Canada, 1995) compared to eight per cent of seniors over the age of 65. Finally, as noted in the previous section, while children suffer more from injuries than do seniors, injuries for seniors are more likely to be fatal.

Children in general also appear to be emotionally healthy. Based on data from the World Health Organization's Survey on Health Behaviours in School Children, most children have high levels of self-esteem and are happy about life. These data are presented in the following tables (Table 2.17, 2.18 and 2.19).

TABLE 2.17
Have Experienced Often in the Last Six Months
% of Children

	Age 11				Age 13				Age 15			
	Male		Female		Male		Female		Male		Female	
	1990	1993	1990	1993	1990	1993	1990	1993	1990	1993	1990	1993
Feeling low/ depressed	10.0	14.0	11.0	16.0	8.0	11.0	18.0	18.0	9.0	13.0	22.0	21.0
Feeling nervous	14.0	17.0	15.0	21.0	11.0	19.0	19.0	23.0	13.0	20.0	21.0	24.0
Difficulties getting to sleep	15.0	28.0	18.0	31.0	14.0	22.0	17.0	27.0	13.0	21.0	20.0	27.0

Source: World Health Organization Survey (1990, 1993).

TABLE 2.18
How Children Feel About Themselves
% of Children

	Age 11				Age 13				Age 15			
	Male		Female		Male		Female		Male		Female	
	1990	1993	1990	1993	1990	1993	1990	1993	1990	1993	1990	1993
I like myself	81.0	89.0	77.0	83.0	82.0	87.0	68.0	73.0	81.0	83.0	68.0	71.0
I have confidence in myself	74.0	82.0	66.0	72.0	74.0	77.0	54.0	61.0	69.0	71.0	48.0	52.0

Source: World Health Organization Survey (1990, 1993).

TABLE 2.19
How Children Feel About Life
% of Children (1990)

	Age 11		Age 13		Age 15	
	Male	Female	Male	Female	Male	Female
Very happy/quite happy about life	89.0	92.0	91.0	84.0	89.0	82.0
Not very happy/Not happy at all about life	11.0	8.0	9.0	16.0	11.0	18.0
Total	100	100	100	100	100	100
Very often/rather often feel lonely	17.0	20.0	12.0	20.0	17.0	23.0
Sometimes feel lonely	64.0	67.0	65.0	69.0	59.0	67.0
Never feel lonely	19.0	14.0	23.0	11.0	24.0	10.0
Total	100	100	100	100	100	100

Source: World Health Organization Survey (1990).

Suicide rates among Canada's children can also be included under the topic of mental health. Suicide rates for young men and women aged 15 to 19 are presented in Table 2.20. The rate of suicide for young men is dramatically higher than for young women, although teenage women are hospitalized for attempted suicide at a rate twice that of young men. Suicide rates have steadily increased over the years, particularly for male youth.

A 1993 report by the United Nations Children's Fund (UNICEF) noted that Canada had the third highest annual youth suicide rate (15.8 suicides per 100,000 people aged 15 to 24), after Australia and Norway (Toronto Star, September 23, 1993).

TABLE 2.20
Youth Suicide Rates, 15 to 19 Years Canada, 1960 to 1991
Rate per 100,000 population

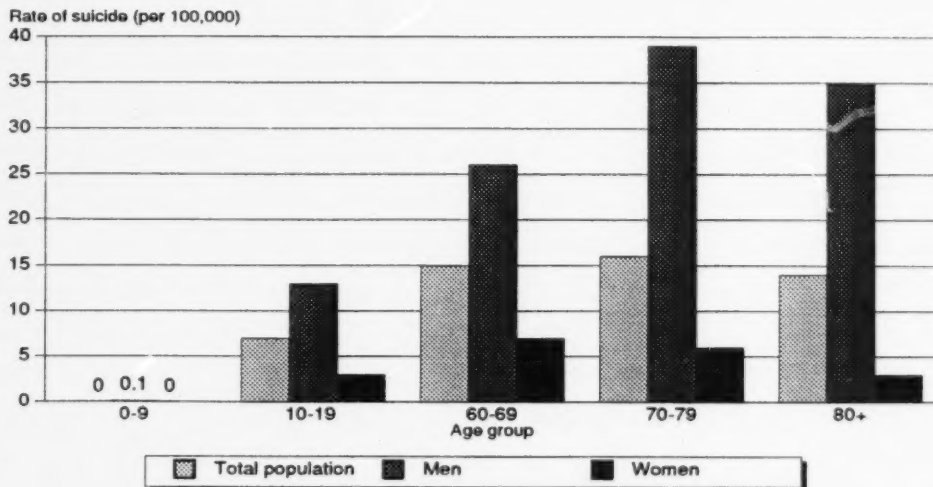
Year	Male (Rate/100,000)	Female (Rate/100,000)
1960	5.3	0.9
1964	5.4	1.7
1968	7.8	1.3
1972	14.2	4.3
1976	16.8	4.3
1980	19.5	3.8
1984	21.4	3.2
1988	21.7	3.2
1991	23	4

Source: Statistics Canada. *Suicide in Canada*. 1994.

While youth suicide rates are high, they are not comparatively higher than that of seniors, particularly male seniors. This difference is even more striking when looking at younger children and when the age range is extended from 15 to 19 years of age to 10 to 19 years of age. As Exhibit 2.1 graphically illustrates, approximately seven out of 100,000 children between the ages of 10 and 19 commit suicide in 1991 compared to approximately 15 out of 100,000 seniors between the ages of 60 and 69, approximately 16 out of 100,000 seniors between the ages of 70 and 79 and approximately 14 out of 100,000 seniors 80 years of age and over.

Mental health problems most often experienced by seniors, approximately 16 per cent, are dementia-related problems and depression (Aging and Seniors' Policy Review, submitted January 1994). In addition to these problems, eight to nine per cent

EXHIBIT 2.1 Suicide Rates of Children, Youth and Seniors in 1991



Source: Santé et Bien-être social Canada, Direction générale des services médicaux, document inédit, 1993.
Royal Commission on Aboriginal Peoples, *Choosing Life*: special report on suicide among Aboriginal People.
February 1995.

of seniors experience anxiety, psychoses, adjustment disorders, substance abuse and delirium. The prevalence of mental health problems in seniors, however, is no higher than other age groups. Research that has been conducted also indicates that seniors tend to have a positive outlook on life (Tandemar Research Inc., 1988).

Based on the above, seniors do not appear to be less at risk than children. The only exception to this is their economic situation which is better than that of children. As already noted, when considering economic situations, it is important to remember the strong differences in economic situation among seniors as well as the disproportionate number of seniors whose existence is barely above the poverty line.

(b) Aboriginals

In 1991, 625,710 people reported themselves as having an Aboriginal identity (Statistics Canada, 1991). Of those reporting Aboriginal identity, 22 per cent and eight per cent were Métis and Inuit, respectively. According to Basic Departmental Data, 533,461 Aboriginals were Registered Indians (DIAND, 1993). The disbursement of Aboriginal Peoples across Canada, as indicated in the survey of Aboriginal Peoples, presented in Table 2.21.

TABLE 2.21
Disbursement of Aboriginal Peoples Across Canada

	Per Cent
Newfoundland	1.6%
Prince Edward Island	.1%
Nova Scotia	1.4%
New Brunswick	.8%
Quebec	9.0%
Ontario	18.4%
Manitoba	15.9%
Saskatchewan	13.9%
Alberta	16.5%
British Columbia	16.2%
Yukon Territory	.7%
Northwest Territories	5.5%

Source: Statistics Canada, Aboriginal People Survey, 1991.

As the above figures show, the majority of Aboriginal Peoples live in Ontario, Alberta, British Columbia, Manitoba and Saskatchewan.

In 1992, the majority of the Registered Indian population lived on-reserve as opposed to off-reserve (315,663 versus 217,798) (DIAND, 1993). Of those living on reserve, 38 per cent resided in urban areas, 42 per cent resided in rural areas, 18 per cent lived in remote areas and 2 per cent lived in special access areas.²⁹ Information presented by Statistics Canada (1994), also indicates that Aboriginal Peoples tend to live in rural areas as opposed to urban areas (58 per cent versus 42 per cent).

Economic Situation

The economic situation of many Aboriginals is one of dire straits. The study on urban poverty conducted by the Canadian Council on Social Development (1996) reported the poverty rate of individuals with Aboriginal origins over the age of 15 in 1991 to be 30 per cent. This is 11 percentage points higher than the poverty rate of seniors over the age of 65. One indicator of poverty, which is of particular relevance to Aboriginals, is the number of people receiving social assistance. The percentage of Indians on-reserve receiving social assistance in 1987 was 19.2 per cent (DIAND, 1989). Comparatively, as Table 2.22 indicates, only 7.2 per cent of Canadians overall were receiving social assistance in 1987.

The number of on-reserve Indians on social assistance continues to rise. In 1992-93, 21 per cent of on-reserve Indians were receiving social assistance (DIAND, 1993). This high rate of poverty will have a substantial impact on the health of Aboriginals as healthfulness (e.g., incidence of physical and mental health problems,

29. Special access areas have no year-round road access to the nearest service centre.

and life expectancy) has been shown to be directly related to income (Aging and Senior's Policy Review, 1993-94).

TABLE 2.22
Social Assistance Recipients
Indians On-Reserve and All Canadians
1981 to 1987

Year	Indians On-Reserve (Per Cent)	Total Canadian (Per Cent)
1981	16.5	6.2
1982	17.1	7.4
1983	17.3	7.6
1984	17.4	7.7
1985	18.1	7.5
1986	18.5	7.5
1987	19.2	7.2

Source: DIAND, *Highlights of Aboriginal Conditions, 1981-2001, Part II, 1989.*

Health and Well-Being

The health and well-being of Aboriginal Peoples is affected not only by their poor economic situation, but also by their poor living and social conditions. In 1986, the living conditions of Aboriginal Peoples were substantially different than those of most Canadians (DIAND, 1989). For example, 9.4 per cent of Aboriginals lived in crowded dwellings compared to 1.8 per cent of Canadians and 13.2 per cent of Aboriginal homes did not have central heating compared to 5.4 per cent of Canadian homes. While the situation may have improved, housing problems for Indians living on-reserve still persist. In 1992-93, over half of the housing units on-reserve required

either renovations or replacement, 13 per cent did not have adequate sewage disposal and nine per cent did not have an adequate water supply (DIAND, 1993). Another indicator sometimes associated with social problems is the number of children in the care of child welfare authorities as children are usually taken into care to promote the well-being of families and to prevent neglect and mistreatment (DIAND, 1989). As Table 2.23 shows, there is a higher proportion of on-reserve Aboriginal children in the care of child welfare authorities than of Canadian children overall.

TABLE 2.23
Children in Care: 1981 to 1987
% of Children

Year	Indians On-Reserve	Total Canadian Population
1981	5.4	1.2
1982	4.8	0.9
1983	4.2	0.8
1984	4	0.8
1985	4	0.8
1986	3.5	0.8
1987	3.2	0.8

Source: DIAND, *Highlights of Aboriginal Conditions, 1981-2001, Part II, 1989.*

The living and social conditions of Aboriginals, coupled with deficient, fragmented and culturally insensitive health care services, can result in many health problems and lower life expectancy (Aging and Senior's Policy Review, 1993-94). Aboriginals have a shorter life expectancy than Canadians overall. In 1991, for example, the life expectancy for Aboriginal males was 65 compared to Canadian males which was 74 and the life expectancy for Aboriginal females was 73 compared to Canadian females which was 81 (DIAND, 1989).

As already noted, suicide rates can be used as an indicator of mental/emotional ill-health. As Table 2.24 shows, while the rate of suicide for Status Indians declined throughout the 1980s, it has always been significantly higher than the suicide rate of Canadians overall (DIAND, 1989). Of interest, however, is the increase in suicide rate for the Inuit. The differences are even more significant when comparing Aboriginal youth to Canadian youth (Table 2.25).

TABLE 2.24
Suicide Rates
Status Indian, Inuit and total Canadian Population
Rate per 100,000 population
1981 to 1986

Year	Status Indian	Inuit - NWT	Total Canadian
1981	42.9	38.0	14.0
1982	39.6	18.4	14.3
1983	34.0	76.9	15.1
1984	35.4	49.9	12.9
1985	34.0	49.9	12.9
1986	34.0	53.9	14.5

Source: DIAND, *Highlights of Aboriginal Conditions, 1981-2001, Part II*, 1989.

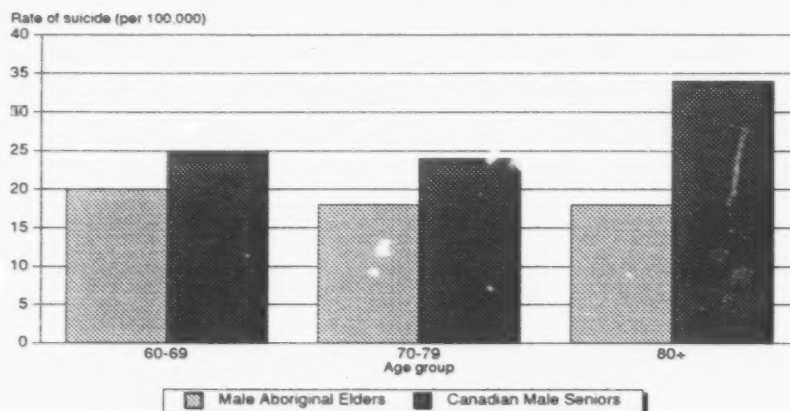
TABLE 2.25
Suicide Rates, 0 to 14 and 15 to 24 Years of Age
Indian and total Canadian Population
Rate per 100,000 population
Average over 1989 to 1993 Period

Category	Indian Rate/100,000	Canadian Rate/100,000	Ratio Indian/Canadian
TOTAL			
☐ 0 to 14 years	3.5	0.6	5.8
☐ 15 to 24 years	77.7	14.6	5.3
MALES			
☐ 0 to 14 years	3.4	0.8	4.3
☐ 15 to 24 years	119.7	24.2	4.9
FEMALES			
☐ 0 to 14 years	3.6	0.3	12.0
☐ 15 to 24 years	35.0	4.6	7.6

Source: Health Canada, *Health Programs Analysis*, 1995.

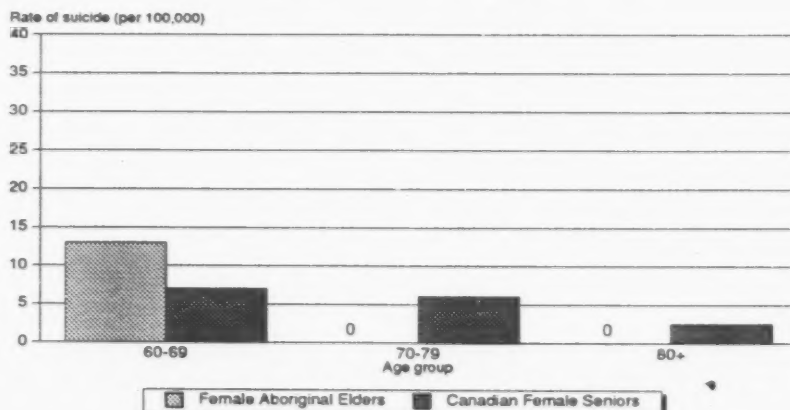
This trend in suicide rates, however, reverses as Aboriginals age. As Exhibits 2.2 and 2.3 illustrate, Aboriginal Elders have a lower suicide rate than their Canadian counterparts. A possible explanation provided by the Royal Commission Report and Aboriginal Peoples (1995) for this reversal is the respect that Aboriginal Elders tend to receive from the rest of the community. It should be noted that this explanation contradicts a point made earlier about how the change from a hunting and gathering society to the present has changed their status.

EXHIBIT 2.2 Rate of Suicide of Male Aboriginal Elders, 1987-1991* Compared to Canadian Male Seniors in 1991



* Does not include the territories or the Pacific Region.
Source: Santé et Bien-être social Canada, Direction générale des services médicaux, document inédit, 1993.
Royal Commission on Aboriginal Peoples, *Choosing Life: special report on suicide among Aboriginal People*, February 1995.

EXHIBIT 2.3 Rate of Suicide of Female Aboriginal Elders, 1987-1991*, to Canadian Female Seniors in 1991



* Does not include the Territories or the Pacific Region.
Source: Santé et Bien-être social Canada, Direction générale des services médicaux, document inédit, 1993.
Royal Commission on Aboriginal Peoples, *Choosing Life: special report on suicide among Aboriginal People*, February 1995.

Based on the above discussion, although there is no question that Aboriginal Peoples face serious challenges to their health and well-being, it is not possible to comment on whether seniors are more or less at risk than Aboriginal Peoples. It does, however, flag the potential for Aboriginal seniors to be particularly in situations of risk.

(c) Immigrants/Visible Minorities

The number of immigrants entering Canada each year steadily increased from 1984 through to 1993 (Dumas & Bélanger, 1996). In 1994, however, this trend reversed. At 217,147, the number of immigrants entering Canada was down by approximately 38,600 from the year before. This decrease reflects, at least in part, Canada's reduction of immigration levels. This did not, however, affect the four main countries from which most of Canada's immigrants come (i.e., Hong Kong, China, the Philippines and India). These four countries make up 43 per cent of all immigration to Canada. As a proportion of the Canadian population, in 1991, immigrants comprised 16 per cent of the total Canadian population (Statistics Canada, 1992).

The disbursement of immigrants across Canada is presented in Table 2.26.

TABLE 2.26
Disbursement of Immigrants Across Canada

	Per Cent
Newfoundland	.2%
Prince Edward Island	.1%
Nova Scotia	.9%
New Brunswick	.6%
Quebec	13.6%
Ontario	54.6%
Manitoba	3.2%
Saskatchewan	1.3%
Alberta	8.8%
British Columbia	16.7%
Yukon Territory	.1%
Northwest Territories	.1%

Source: Statistics Canada, 1992.

As the above statistics show, by far the majority of immigrants reside in Ontario. Immigrants also tend to reside in urban areas (90 per cent) over rural areas (10 per cent) (Statistics Canada, 1994).

Economic Situation

The economic situation of visible minorities in Canada closely resembles that of Aboriginal Peoples. According to the Canadian Council on Social Development study (1996), the poverty rate for visible minorities in 1991 was 27 per cent. This is eight percentage points higher than the poverty rate of seniors over the age of 65. As already noted, high rates of poverty will have a substantial impact on the health of

individuals, in this case visible minorities, as healthfulness has been shown to be directly related to income (Aging and Senior's Policy Review, 1993-94).

Health and Well-Being

The level of health of immigrants (European and non-European) first entering Canada is higher than that of Canadian-born residents. A recent study (Chen, Ng and Wilkins, 1996) shows that immigrants have fewer chronic conditions, they are less likely to have any long-term disability and they have fewer overnight stays in hospitals. One of the reasons for this is due to the selection of people in better health at the time of immigration (called the "healthy immigrant effect"). Once immigrants have been in Canada for more than 10 years, however, the prevalence of chronic conditions and long-term disabilities approaches the same levels as the Canadian-born population. The three most chronic conditions noted were joints, allergies and hypertension. A comparison between Canadian-born, European immigrants and non-European immigrants is presented in Table 2.27.

TABLE 2.27
Specific Chronic Conditions
Canadian Born, European Immigrants and Non-European Immigrants
After 10 Years

Chronic Condition	Canadian-Born (Per Cent)	European Immigrants (Per Cent)	Non-European Immigrants (Per Cent)
Joints	24.5	25.7	20.0
Allergy	19.5	19.6	20.0
Hypertension	9.7	10.2	10.3

Source: Chen, Ng, Wilkins, *The Health of Canada's Immigrants in 1995-95*, 1996.

In the literature reviewed for this project, there was very little information on whether the health care needs of immigrants were being met. The only study reviewed which examined this issue was the study by Chen et al. (1996). According to this study, there was no indication of health care needs not being met based on immigrant status alone and regardless of years living in Canada. There have, however, been studies in the United States which have highlighted barriers to accessing appropriate health care which exist for ethnic minorities. One study (Kohn, 1995), for example, cited the following barriers:

- ☐ American medicine is an alien culture;
- ☐ language difficulties; and
- ☐ customs not understood or respected.

Another American study (Gottsfield, 1995), reported the underutilization of mental health services by minority patients. A possible explanation as to why this does not appear to be a problem in Canada is that Canada has adopted a specific health care policy for immigrants (Bollini, 1992). This health care policy helps to remove economic and administrative barriers facing immigrants' access to health care, while at the same time acknowledging their cultural differences, values and beliefs. Having this policy,

however, does not guarantee effective health care delivery to the individuals it is targeting.

Based on the above, it appears that immigrant status/ethnicity is not in itself an indicator of risk. Other factors must come into play (e.g., poverty, old age) to place this population into situations of risk.

2.4 Current Needs of Seniors

Of the literature reviewed for this project, the annual *Elder Monitor* (1995) by Synergetics Consulting provided the most useful information on seniors' self-identified needs. According to the survey, better income or financial security was the number one factor that seniors identified as contributing to their well-being (18 per cent). This factor was consistently the number one factor identified across gender (male = 20 per cent, female = 16 per cent), marital status (married = 18 per cent, separated = 32 per cent, divorced = 23 per cent, widowed = 14 per cent, single = 20 per cent) and region (Atlantic = 13 per cent, Quebec = 22 per cent, Ontario = 17 per cent, Manitoba = 17 per cent, Saskatchewan = 19 per cent, Alberta, 19 per cent, British Columbia = 14 per cent). Next to income security, the most highly rated factors were:

- ☐ good health in general — eight per cent;
- ☐ guaranteed health care — eight per cent;
- ☐ regular exercise — seven per cent; and
- ☐ personal relationships — seven per cent.

Notes from a meeting between the Minister of Health Canada and representatives of seniors organizations prior to *Connections 95* can also provide insight into the top-of-the-mind issues of concern to today's seniors (September, 1995). During the meeting, representatives of seniors organizations highlighted the following issues of concern:

- ☐ health issues;
 - fear of the demise of Medicare due to the reduction in transfer payments to the Provinces
 - future of health care and the preservation of the Canada Health Act
 - relevance and impact of research undertaken by the National Forum on Health on government programs
 - potential weakening of the health care system as a result of provinces moving from standards to principles
 - fear of the private sector assuming a larger role in health care (e.g., private clinics)
- ☐ caregiving issues;
- ☐ intergenerational issues; and
- ☐ the need for an advocate for seniors in government.

Given that this meeting was with the Minister of Health Canada, it may not be surprising that the primary issue of concern was health related.

While there was no information on self-identified needs of seniors within the other literature reviewed for this study, the importance of quality of life to seniors was evident. The main factors identified by seniors in a study by Tandemar Research (1988) as influencing their quality of life included health, financial security, having a positive attitude, being able to have one's own housing and access to family and friends. This study also found that "good quality of life" was practically synonymous with being independent which was defined as having control over one's life and making one's own decisions. In a later study (Optima, 1991), independence as a component of quality of life appeared again as being one of the uppermost concerns of Canadian seniors. In this study, independence was defined as including self-respect, sense of freedom, happiness, the ability to make ones own choices, health, financial security, transportation, dignity and affordable housing.

A review of the literature conducted for this study has also highlighted areas where there are still unmet needs. In terms of demographics, as discussed in the first section of this chapter, the majority of seniors are women, most of whom live

alone. Aboriginal seniors were also identified as being a group more at risk than seniors in general. Although there have been improvements in many areas (e.g., financial security has increased, fewer seniors are victims of homicide), there are still areas which need to be addressed. The two most prominent areas identified in the literature are transportation, particularly for those living in rural and remote areas, and caregiver support. These are both seen as being important. Finally, it is believed that while causes of death such as cardiovascular disease may be controllable in the future, other disabilities such as arthritis, rheumatism and mental disability will continue.

2.5 Summary

The literature and database reviewed in this chapter covered many topics including demographics of seniors, their economic situation, health and safety, independence, formal and informal support, attitudes and seniors at risk. The following key findings identified in the literature were presented in this chapter.

- ❑ The population is aging. By 2036, it is estimated that 23 per cent of the Canadian population will be over 65 years old (compared to 12 per cent in 1991). Today, more than 58 per cent of seniors are women.
- ❑ Aboriginal seniors represent less than one per cent of the senior population. The life expectancy of Aboriginal seniors is significantly lower than non-Aboriginal seniors.
- ❑ The economic situation of seniors has improved during the 1980s. The poverty rate, however, remains higher among seniors — especially those living alone — than in the rest of the population.
- ❑ Male seniors have higher income than female seniors.
- ❑ The most common health conditions of seniors are heart-related illnesses and joint-and-limb problems. Although a minority of seniors are using the majority of health resources consumed by to this population, the senior age group requires more medical assistance than other age groups

in the population. Statistics also tend to show that the nature of the causes of hospitalization changes with age.

- ❑ Seniors are less often victims of violent crimes than the rest of the population but they express higher levels of fear of such victimization.
- ❑ Most seniors live in a family household, outside an institution. Proportionally more senior women live alone than do senior men.
- ❑ Seniors primarily use public transportation as to other means. More senior men, however, hold a drivers licence and/or own an automobile than do senior women. Many seniors living in small towns or rural areas do not have access to public transportation.
- ❑ The most important sources of care are from informal sources and demand for informal care will probably increase in the coming years. Most caregivers for seniors are women, most often wives and daughters.
- ❑ Seniors tend to have more positive views about seniors in general than do non-seniors.
- ❑ Although there is no evidence of a growing intergenerational conflict on this issue, some authors warn that the debate over present and future use of health and social spending may provoke conflicts between the younger and older generations.
- ❑ Aboriginal seniors, senior women and seniors living in rural areas and small towns may be considered as being more at risk than most other seniors.
- ❑ Seniors do not appear to be less at risk than children. Regarding health, it appears that immigrant status/ethnicity is not in itself associated with higher risk. Other factors such as age and income can put some fragments of the immigrant/ethnic population at risk just as they do for other social groups.
- ❑ Health and income are the most important determinants of well-being according to seniors. We may infer from this that some of their most important needs are health and income related.

CHAPTER

3

ADDRESSING PRIORITIES AND
NEEDS

3.1 Health Canada's Mandate

The *Department of Health Act* (Bill C-95, recently passed by Parliament, July 19, 1996) outlines the role to be played by Health Canada with respect to the health of Canadians. Some specific responsibilities as outlined in the *Act*, and which are consistent with Health Canada's role within the DAS/S, are as follow:

- ☐ the promotion and preservation of the physical, mental and social well-being of the people of Canada;
- ☐ the protection of the people of Canada against risks to health and the spreading of diseases;
- ☐ investigation and research into public health, including the monitoring of diseases; and
- ☐ cooperation with provincial authorities with a view to the coordination of efforts made or proposed for preserving and improving public health.

The key difference between the *Department of Health Act* and the previous *Department of National Health and Welfare Act* (R.R. Chapter N-9, s.1), which was in place

when the Seniors Strategy was initiated, is that income security programs (i.e., Canada Pension Plan, Old Age Security, Guaranteed Income Supplement) and the cost sharing of welfare programs (i.e., through the Canada Assistance Plan) are no longer the responsibility of Health Canada. Although this change has raised the question as to whom should be responsible for the programs under the Seniors Strategy, Health Canada has continued to oversee this initiative under its mandate.

Health Canada's role, as described in the *Health Canada 1995-96 Estimates, Part III*, is to help Canadians maintain and improve their health. The emphasis is on fostering healthy individuals, healthy families and a healthy society, with an emphasis on disease prevention and health promotion. The work of the Department includes:

- ☐ financial support to provinces and territories for insured health care;
- ☐ cooperation with provinces and territories in health system renewal and in addressing identified health-related issues;
- ☐ health protection and consumer safety by refocussing and strengthening Canada's health intelligence network;
- ☐ the fostering of public health research;
- ☐ activities aimed at improving health care and health services in Canada;
- ☐ activities aimed at disease prevention and the promotion of good health; and
- ☐ activities targeted at issues affecting specific groups in society (e.g., women, children, seniors).

Given the constitutional division of responsibilities, a large proportion of the work of the Department involves collaboration with provincial and territorial authorities in efforts to maintain and improve the health of all Canadians.

The activities of the DAS/S are clearly relevant to the Department's legal mandate, as described above, as well as its overall mission — to help the people of Canada maintain and improve their health. Aspects of the DAS/S are also directly related to specific Departmental goals, as stated in the *Health Canada 1995-96 Estimates, Part III* — for instance: to foster active health system partnerships with provinces, territories and others; to give increased priority to initiatives that redress the most significant health inequalities in Canada; and to provide leadership on health promotion, disease prevention and health strategies.

(a) Population Health Strategy

As one of its four main business lines, Health Canada has adopted a population health strategy (Health Canada, 1995). The population health approach focuses on the entire range of individual and collective factors and conditions (including individual characteristics, social and economic factors, and physical environments), as well as the complex interactions among these, that determine the health and well-being of Canadians (Federal/Provincial/Territorial Advisory Committee on Population Health, 1994). Strategies to improve population health are based on an assessment of all factors and conditions of risk and benefit that may apply across the entire population, or to particular sub-groups within the population. It is also assumed that improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional health system, as well as collaboration among different sectors and levels of government.

Underlying the population health approach are the following premises regarding determinants of health (Health Canada, June, 1996):

- ☐ Health status improves as one moves up the income and social hierarchy.

- ☐ Social support from families, friends and communities is associated with better health.
- ☐ Health status improves with level of education.
- ☐ Unemployment, underemployment and stressful work are associated with poorer health.
- ☐ The values and norms in society influence in varying ways the health and well-being of individuals and populations.
- ☐ Gender is an important determinant of health. For instance, the embodiment of gendered norms in social institutions and practices has subordinated women, inhibited their achievement of political, cultural, social and economic equality and, consequently, impeded their attainment of optimal health status.
- ☐ Some persons or groups may face additional health risks due to a socio-economic environment largely determined by dominant cultural values that can contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture, and lack of access to culturally appropriate health care and services.
- ☐ Physical factors in the natural environment, such as the quality of air and water, are key influences on health. In addition, factors in the human-built environment (e.g., housing, workplace safety, community and road design) are important influences.
- ☐ Social environments that enable and support healthy choices and lifestyles, as well as people's knowledge, intentions, behaviours and coping skills for dealing with life in healthy ways, are key influences on health.
- ☐ Prenatal and early childhood experiences exert a powerful influence on subsequent health, well-being, coping skills and competence.
- ☐ The biology and organic make-up of the human body (i.e., genetic factors) are fundamental determinants of health.
- ☐ Health services — in particular, those designed to maintain and promote health, to prevent disease and to restore health and functioning — contribute to population health.

With the population health strategy, Health Canada uses an evidence-based approach to identifying and focusing its investments on the conditions that exert the greatest influence on the health of the Canadian population. This approach also incorporates a life cycle framework, whereby population health programming is tailored to the unique health determinants and needs at three stages of life — children and youth, midlife and later life. This strategy should, therefore, assist the DAS in identifying seniors most at risk and the conditions that put them at risk. This will allow the DAS to better address the needs of Canadian seniors.

The Division of Aging and Seniors also contributes to the business line *Management of Risks to the Health of Canadians — Products and Disease Control*, as well as to the Health Canada core function of health surveillance through its Aging-Related Diseases Program and its epidemiological research on aging-related diseases. The Seniors Independence Research Program also contributes to the core function of research.

3.2 Provincial/Territorial Responsibilities

Provincial and territorial governments also carry some responsibility for delivering programs and services to seniors based on the division of power between the two levels of government. This division was initially established in the *British North America Act (BNA Act)* of 1867. The *BNA Act* established a fundamental division of jurisdictional authority: provincial/territorial governments became responsible for issues which are considered to be of a local nature, including education, social welfare, health, and property; the federal government, on the other hand, is responsible for defense, foreign affairs, and other areas not specifically assigned to the provinces/territories, and has primary taxation powers to raise money (Beatty, 1988; Ip, 1991;

Lightman and Irving, 1991). Hence, the delivery of health services is a provincial/territorial responsibility.

Provinces/territories are required to administer their health programs according to the principles of the *Canada Health Act* which stipulates that the federal government cost-share medical fees with the provinces (NACA, March 1991). These principles are:

- ☐ comprehensive coverage of insured services;
- ☐ universality;
- ☐ interprovincial portability;
- ☐ public administration; and
- ☐ accessibility.

If provinces do not adhere to these principles (e.g., extra-billing), then federal funding could be reduced.

Recently the Canada Health and Social Transfer (CHST) was established by the federal government (Thompson, 1995). The CHST will allow provinces/territories to establish their own priorities in allocating federal transfers to health, education and social services. As there will no longer be common standards, disparities between provinces may become greater. Regional funding priorities for programs with the DAS/S, however, are set in consultation with seniors, community groups and organizations and government representatives. It would be expected, therefore, that funding would continue to be targeted to those areas where it will have the greatest impact.

In addition to health services, the provincial/territorial governments have legislative jurisdiction to establish other programs such as income security and housing (NACA, March 1991). Although they have this legislative jurisdiction, only six provinces and the two territories have used this prerogative to establish income

security programs for seniors and six provinces have implemented housing allowance programs for seniors.

3.3 Suggestions for Addressing Needs

As shown in previous sections, today's seniors in Canada form a fairly diversified group; significant differences exist between and among sex, income and ethnic groups and between different regions and localities on many aspects. These and the uncertain future of Canada's seniors' support mechanisms present important challenges to our policy makers. As indicated in the literature, there may be opportunities for reform in a number of domains regarding seniors.

Many observers not only describe what can be called the senior's reality but also discuss public policies and offer suggestions. In general terms, Marshall (1993) proposes the following four guiding principles for an appropriate framework for public policy on aging and health:

- ☐ Policy must be multisectoral. Health depends on economy, nutrition, housing, environment and education.
- ☐ There must be a commitment to equity.
- ☐ Healthy public policy initiatives should, ideally, be broadly participatory.
- ☐ Must have an ecological perspective which places humans in a broad context of the physical and social world.

This holistic approach is based on massive research that shows the systemic nature of social life and the interdependency of the different public policy elements that address it.

Of course, the major obstacle to an appropriate public policy on seniors remains the state of public finances. Walker (1990) and many others argue, however, that the debate over the future of public health and pension programs has put too much attention on public finances and demographics and not enough on political and ideological factors. Pension provision, for example, is not only determined by demographics. In 1984, the share of national income taken by pension expenditure ranged from 16.9 per cent in Italy, to 14.3 per cent in France, to 7.7 per cent in Britain³⁰. As the author points out, these figures illustrate that pension provision is not the simple creature of demographic change in the current debate about the economic consequences of societal aging. In fact, it is primarily political decisions that determine the overall proportion of national resources that are devoted to pensions and not aging by itself.

This being said, most western governments still prefer revising their social policies to limit their current and future costs. New approaches are suggested and developed and these changes are not always in contradiction to the needs of seniors. For instance, some changes regarding caregiving, according to observers, may offer opportunities to improve care at limited costs.

**(a) *Supporting Community-Level
Structures and Informal Care***

One important trend is the decentralization of senior support services to a community level. For Addleman (1995), government policy and financial incentives can play an important role in creating support systems that are community rather than institutionally based. He cites Vadleck who thinks that long-term care policy should

30. In 1990, the percentage of population over 65 was 14.7 per cent in Italy, 14 per cent in France, and 15.6 per cent in Britain (U.S. Senate Special Committee on Aging *et al. Aging in America; trends and projections*, 1991).

be based on funds following the patient rather than a "bureaucratic category defined as a level of care or a kind of benefit". Community-based, long-term care benefits may eventually become client-managed vouchers, says Vladeck.

However, giving responsibilities to community-level structures may not be the ideal approach, says Walker (1991). In this article, the author recalls the British experience and how this strategy only increases the burden on informal caregivers. Combined with a reduction of domiciliary provision, the conservative government has been appealing to the wider "community" to provide increased input and has devoted comparatively small sums of money to several initiatives such as a "Helping the Community to Care" initiative designed to encourage it to do so. For the author, the fundamental flaw in this approach is that it is based, at best, on an overoptimistic view of the existing potential contribution of the wider community. According to Walker's observations, it is bound to increase the burden of family caregivers and increase the strains on the caring relationship. Therefore, the interests of *both* senior people and their caregivers lie in opposition to this development.

(b) Assisting Caregivers

For many, support for informal care should still be pursued and developed. Assistance can take many forms, including respite care, daycare services for the caregiver's own children and transportation for example. According to Gee and McDaniel (1993), this support should be targeted towards middle-aged women who form the bulk of caregivers but are in need of assistance themselves. The authors note that policy-makers have taken this source of caregiving for granted and caregiver-support strategies should be developed.

Training in caregiving may also be developed, according to Smith and Longino (1994). Notwithstanding caregivers' characteristics, it is suggested that the abilities and skills of informal caregivers be developed in order to reduce the strain that has been and will be forced by the sociodemographic and economic trends discussed earlier. The authors note that educational gerontologists should have a much larger role to play in meeting this need for information.

For many, there are opportunities to assist caregivers but again, Walker recalls past experiences to show that the state should not give all caregiving responsibilities to individuals. Coercive measures, in particular, would be a mistake:

"In the field of care of older people, coercion has rarely proved successful. The idea that the state could compel families to offer love and gratitude to their older parents was given little credence even by the administrators of the English Poor Law. They found that even the most obvious needs of older people failed to call forth sufficient informal support, despite coercive measures." (Walker, 1991:101)

No family should be expected to care but there could be, at least in the U.K., a better coordination between formal and informal caring mechanisms, according to the author. There should not be a rigid division between formal and informal sectors. Change should be initiated in professional values and attitudes between the formal sector, pursues the author, if a partnership between the formal and informal sectors is to be developed. This is primarily a matter of increasing accountability of professionals to both older people and their caregivers. A long term goal would be to change the experience of welfare care from passive to more participatory (on the part of clients and caregivers) in the definition of need and policy responses to it. Still, there will always be an important role for professional groups, according to Walker (1991: 108-109).

(c) Prevention, Self-Help and Self-Care

Of course, developing preventive approaches may be linked to these assistance strategies. Marshall (1993) thinks that current policy focuses on sick seniors rather than on the "well" elderly. In this line of thought, preventive measures should be at least as important as curative ones. Baker (1988) points out that many authors suggest that major reforms rather than expansion are needed in the health-care system to focus more on prevention, community and home care, and the use of a variety of practitioners.

Multidisciplinary initiatives in a variety of fields would prevent major health problems that are not always linked to a person's physical characteristics. Marshall writes that policy initiatives to enhance the health of seniors should focus on income security, housing and other social determinants, rather than specifically on health or medical matters. Health promotion and disease prevention goals should be set, according to the author.

Prevention may, in particular, be enhanced through self-help and care development. As mentioned earlier, most seniors living alone are women and as Baker (1988:59) points out, older women could develop new skills such as automobile and home repairs, and a more assertive approach to financial investments or paid work. These and other abilities may be developed to help senior women help themselves and improve their living and health conditions. According to Smith and Longino (1994), the trend toward independent residence and higher levels of education among seniors suggests that better self-care is both needed and achievable. High tech may become useful here: according to Addleman (1995:62), computers, internet and CD-ROM technology will vastly expand learning, research and medical self-care opportunities for seniors.

An experiment in Denver indicated that counselling offered to seniors during their stay in hospitals may be a good strategy to develop self-care. In this project, trained discharge counsellors assessed patient needs, provided information about post-hospital care options and performed follow-up with discharged patients to ensure that the placement decision was the most appropriate one. The study revealed that with special counselling, patients were able to return home more often and, hence, were sent to nursing homes less often (52 per cent of patients who received counselling were able to return home, compared to 34 per cent of those who did not receive counselling) (R. B. Addleman, 1995:62).

Although many studies show that physical exercise does not greatly extend the life-span of older seniors, it does improve their quality of life (Shephard, 1993). Research studies cited in Shephard's article also indicate that physical activity allows seniors to maintain personal independence longer and leads to a substantial reduction in demand for both acute and chronic medical services. In this sense, exercising may be considered to be an effective preventive measure that benefits both seniors and society in general.

Appropriate information about findings such as these should be made available to seniors. This is not always the case, according to some participants of the SIRP Symposium on "Putting Research on Aging to Work" (1994). From the seniors' perspective, timely dissemination of research results would help individual self-help, with benefits to both independence and quality of life. This means better home, community centre or library access to information. Dissemination of research results in general is, however, too often deficient, according to many participants of this seminar and some expressed the need to link research financing to effective communication of results. Researchers do not always seek seniors' views at the planning stage of their studies and research results are often inaccessible to non-expert readers.

3.4 Views on Current Policies

Limits to current policies are also discussed in the literature. In the article cited earlier, Marshall (1993) comments that those who think about aging and health policy are few in numbers and that there is not much that is systematic about aging and health policy in Canada. It is considered by the author to be ill-developed and often ill-advised; its policies are fragmented and sometimes contradictory.

(a) Barriers to a Sound Policy

Marshall identifies two important barriers to a sound seniors policy in Canada. As indicated earlier, the author finds that the focus of policy on seniors is too narrow; there is too much focus on costs, health and pathology. According to Marshall, this results from a narrow focus on the part of policy makers, which is a barrier in itself to a sound policy.

The second type of barrier identified by the author is more structural. According to Marshall, there is a lack of expertise: Canada lacks proper organizational *apparati* for providing health policy formation. The U.S. for example has the National Institute of Aging, Surgeon General which can greatly help policy makers. For Marshall, Canada also has an "uncoordinated panoply" of aging and health policy initiatives at federal, provincial and local levels. There is room for improvement in the coordination between government structures:

Some intergovernmental coordination has been achieved but the degree of federal-provincial coordination has not been great. Cooperative efforts between federal and provincial sectors in aging and health policy are indicated in the existence of a federal-provincial-territorial committee on long term care. This

mechanism, however, is not judged to be highly influential or successful (1993: 154).

There is also a lack of data and data flow: most provinces do not have the resources for accumulating and exploiting health data. As well, there are many sources of information but systematic comparisons of health services and long-term care data are difficult to make because there are no accepted and uniform definitions of the levels of care across the country. Jurisdictional barriers play a role here and limit the flow of information.

***(b) Risks Associated with Simple
Cutbacks and Privatization***

Evidence from the U.S. also tends to show that while cutting back formal public care, governments do not always place enough attention on informal care. In their article, Smith and Longino (1994) conclude that government policy, in attempting to contain the cost of formal care without providing the resources for informal givers to take up the slack, has worsened the situation. The reason for the "bad policy work", they argue, is an institutional point of view that asserts that problems can best be solved scientifically in organized ways using trained personnel. Most problems are actually solved by individuals and their family members and friends in noninstitutional and informal ways.

Another American observer (Addleman, 1995:60) notes that the fragmented network of eldercare (nursing homes, meals on wheels, and interest groups, for example) is symptomatic of the piecemeal approach that prevails in the entire healthcare delivery system in the United States. The problem is that no one acts as an organizer or coordinator. Each caregiver or provider thinks only in terms of special interests or commitment, failing to see eldercare as an integrated system and

overlooking the interconnections of eldercare problems. Consequently, too many well-intentioned caregivers and providers possess a "but that's not my department" mindset. To some extent, this may be also true in Canada; privatization of services, including health care, is slowly progressing in Canada according to some studies and may contribute to this. In a recent document, the Canadian Medical Association shows that more and more Canadians are obtaining health services through the private sector³¹. Budget constraints have lead to a trend of privatization of social services that started in 1980, according to Gee and McDaniel, (1993). For them, risks of privatization involve access determined by wealth of individual, discontinuation of certain services, absence of standards of services and increase use of non-professionals.

Budget constraints and privatization may, in the long run, affect quality of care and the above mentioned authors remind us that any failings of policies for seniors are felt more acutely by women, partly given women's greater life expectancy and partly because gender-based injustices accumulate with age.

3.5 Summary

Many authors and specialists offer suggestions for addressing seniors' needs. Decentralizing services and delegating some responsibilities to community-level structures are suggested by some and apparently, many governments have already moved in this direction. The financial advantages of these strategies may be attractive to governments but according to some observers, this trend may only mean leaving more responsibilities to informal caregivers without giving them any more support. Still, efforts from community-level structures or other institutions may be useful for seniors, especially if they offer true support to informal caregivers, promote self-care, are well coordinated, and are geared towards prevention.

31. *Le Devoir*, July 16th, 1996, p. A2.

In the time being, the efficiency of current policies is limited by many factors, according to some observers. For one, structural problems including administrative barriers cause problems in Canada and only a more holistic approach would produce a sound seniors policy. Regarding privatisation of services, other observers in Canada and abroad see many risks in this recent trend including uncoordinated services and growing disparities among seniors who receive services.

CHAPTER

4

**DESCRIPTION OF THE DIVISION
OF AGING AND SENIORS/SENIORS
STRATEGY**

In 1994, the majority of Health Canada's Seniors Strategy components were merged into the Seniors Directorate in 1994. In 1995, the Seniors Directorate was renamed the Division of Aging and Seniors following restructuring which occurred in the Health Promotions and Programs Branch. The Division of Aging and Seniors/Seniors Strategy (DAS/S) is a composite of the Division of Aging and Seniors and the Seniors Strategy and reflects their interconnectedness. In this chapter, the history and objectives of the DAS/S will be outlined followed by a discussion of each of its program elements.

4.1 History and Current Context of the Division of Aging and Seniors/ Seniors Strategy

(a) History

The Division of Aging and Seniors/Seniors Strategy is the result of an evolution of programs aimed at seniors over the past two decades. This evolution can be traced back to 1972 when the then Department of Health and Welfare created the first New Horizons program. The purpose of this program was to fund projects that were not only more meaningful and beneficial to older, retired Canadians and their communities, but were also managed and delivered by them. In 1980 the Minister of Health and Welfare established the National Advisory Council on Aging (NACA), based on a recognized need for independent advice and research on seniors' issues and related issues on aging. As an independent body, the purpose of the NACA was to assist and advise the Minister on all issues of concern to seniors. Seven years later, in recognition of an aging population, a Minister of State for Seniors was appointed.

Falling on the heels of the appointment of the Minister of State for Seniors, a five-year Seniors Initiative (also referred to as the Seniors Strategy) was announced six months later (February 1988). In addition to increasing the funding for the New Horizons program and the financial support for the NACA, funding was provided for the Seniors Independence Research Program (SIRP) and the Seniors Independence Program (SIP). The SIRP has as its mandate the conduct of research on diseases (e.g., Alzheimers) that inhibit seniors' independence. Through SIP, funding is provided to encourage collaboration between the voluntary sector and seniors on the development of innovative approaches that would support seniors' independence and their quality of life. Finally, a Seniors Secretariat was created to provide support to the

Minister of State for Seniors as well as to consult with other departments, provincial/territorial governments and NGOs for the purpose of sharing information, sponsoring meetings and workshops and developing publications. In addition to the above, financial support was also provided to the Health Policy Division to enable the provision of analysis, advice and information to the Minister of Health and Welfare and the Minister of State for Seniors on health, social and policy issues related to seniors. Although these components all fell under the Seniors Initiative, they were all separate entities and were dispersed within the Department.

In 1993 the Seniors Strategy was renewed by Cabinet for another five year period. By building on past achievements and through the introduction of new innovative elements, the renewed Strategy was to lead to the enhancement of independence and quality of life for seniors. The Seniors Strategy received \$170M in funding (later reduced by half), which included \$149M to be used for funding seniors community programs, to be allocated over the five years. In addition to this funding, the renewed Strategy also had access to A-base funds allocated to New Horizons and the NACA, making a total of \$234M available to the Seniors Strategy. In addition to the components that existed under the original Initiative, two new components were added to the Strategy: the Ventures in Independence funding program and the development of a Federal Policy on Aging. Through the Ventures in Independence funding program, partnerships between seniors and business, labour and other levels of government are developed for the purpose of addressing issues on aging and independence. The Federal Policy on Aging was to be developed to support a comprehensive agenda for action on issues of concern to seniors now and in the future.

Since its renewal, there have been a number of events that have impacted on the new Seniors Strategy. Two months after its renewal, the government went through a restructuring which resulted in a re-mandated health portfolio, turning the focus of the Department onto the challenges facing Canada's health care system. It

was also at this time that the Minister of State for Seniors was disestablished, transferring the responsibilities over to the Minister of Health who then also became the Minister Responsible for Seniors. Finally in 1993, the *Report of the Auditor General of Canada* expressed a need for seniors-related activities to be coordinated and rigorously evaluated.

Following an internal review at Health Canada and taking into account the recommendations of the Auditor General's Report, a Seniors' Directorate was created in 1994. This Directorate was later renamed the Division of Aging and Seniors (DAS) following a restructuring of the Health Promotions and Program Branch in 1995. In addition, the majority of Health Canada's seniors programs, including the majority of the Seniors Strategy's components (i.e., Seniors Secretariat, the Secretariat to the NACA, Seniors Community Programs and some parts of the SIRP) were merged and placed under the Directorate's mandate. This, in effect, brought most of the advisory, policy, research, programming, communications, consultations and administrative functions of the seniors programs together into one organization. Through this merger, Health Canada gained control over the coordination of the elements contained under the renewed Seniors Strategy and, through the DAS, is able to monitor the Strategy. While the Seniors Strategy was renewed with a five year mandate, it will sunset after four. Also, the Federal Policy on Aging which was to be pursued as part of the renewed Strategy was relinquished. This was replaced by the Framework on Aging being developed under the aegis of the Ministers Responsible for Seniors (the Federal/Provincial/Territorial component) and the Interdepartmental Committee on Seniors Issues (the federal component).

Within the Division, the New Horizons, the Seniors Independence Program and the Ventures in Independence funding programs were amalgamated into the New Horizons: Partners in Aging (NH:PA) program in April, 1995, although administratively they had already been amalgamated under Seniors Community

Programs in 1993. The NH:PA now serves all applicant groups of the former three programs. With the creation of NH:PA, new program objectives (e.g., at risk, innovation and evaluation, partnerships) and new program procedures (e.g., priority setting, solicitation, review) were introduced.

Not all elements of the Seniors Strategy were absorbed by the Division of Aging and Seniors. There are four organizations which, although they reside outside of the DAS, collaborate with the Division in delivering parts of the Seniors Strategy. These organizations are: the Health Promotion and Programs Branch Regional Offices (HPPBRO); the Extramural Research Division of the Research and Program Policy Directorate and the Health Promotion and Programs Branch; the National Advisory Council on Aging; and the Health Policy Division which is part of the Policy and Consultation Branch. The HPPBRO shares joint responsibility with the DAS for the delivery of seniors' community funding programs. The Extramural Research Division administers the SIRP, including the conduct of peer reviews and the management of finances for seniors research. The National Advisory Council on Aging, with research and secretariat support from the DAS, both sponsors and conducts research on issues related to aging as well as provides the Minister with advice on seniors issues. The Policy and Consultation Branch assists the Minister through research and analysis and the provision of policy advice on issues and activities such as federal/provincial/territorial health renewal. To reflect the fact that the Division of Aging and Seniors and the Seniors Strategy are now interconnected, they are referred to as the Division of Aging and Seniors/Seniors Strategy (DAS/S). For 1995-96, the total budget for the DAS/S was \$33,118,000.

(b) Current Context

There are seven functional units within the Division of Aging and Seniors:

- ☐ Office of Consultation, Coordination and Partnership Development;
- ☐ Office of Public Affairs;
- ☐ Program Development and Management Unit;
- ☐ Planning and Management Services Office;
- ☐ Office of Strategic Policy;
- ☐ Office of Strategic Research; and
- ☐ Aging-Related Diseases Program.

Members of these functional units work together in the planning, development and implementation of the DAS' program elements. These functional units also work together on client, issue and project teams which have been established to implement priorities as identified in the Division's strategic plan. The Division's current priorities include:

- ☐ *to develop a Framework on Aging including a federal/provincial/territorial monitoring and assessment model;*
- ☐ *to enhance the understanding and dissemination of knowledge concerning seniors living in situations of risk or the prevention of risk situations;*
- ☐ *to enhance the understanding and dissemination of knowledge on the broader determinants of healthy aging;*
- ☐ *to develop strategies to reduce preventable injuries;*
- ☐ *to develop strategies to reduce the inappropriate use of medication by seniors; and*
- ☐ *to support NACA priorities.*

The outputs of the Division's activities, which include goods and services that have either been produced as a result of the DAS activities or are directly controlled by the DAS, are varied. These outputs, some of which are more tangible than others, range from the publication of education materials to the development of partnerships and networks to increase information and knowledge of seniors and aging. Examples of specific outputs include:

- ☐ advice to the Minister on aging-related issues;
- ☐ workshops, seminars and reports on the results of funded community and research projects;
- ☐ development of models and resource materials aimed at helping seniors at risk to retain their health, independence and well-being; and
- ☐ advice and responses to inquiries by seniors, seniors organizations, other levels of government, academics and the general public.

The impacts and effects of these outputs may be short or long term. Examples of short-term impacts (i.e., those impacts achievable before the end of the current Seniors Strategy) include: increased harmonization and integration of the seniors programs and policies at the federal level; increased number of evaluations of seniors programs and services; and the development of more innovative programs and services targeting seniors, including those living in situations of risk. Examples of long-term impacts (i.e., those resulting in societal change) include: more seniors living independently in their community; through awareness, a reduction in aging-related diseases influenced by life style choices; less stigma attached to seniors and aging; and an increased participation by seniors in their community, through the expertise and skills gained by their participation in the development, management and delivery of funded community projects.

(c) Objectives

The Division of Aging and Seniors' primary responsibility is the implementation of the Seniors Strategy. This is achieved not only through its own operations, but also through the activities of its partners: HPPBRO, Extramural Research Division, National Advisory Council on Aging and the Health Economics and Systems Analysis Division³². Prior to the merging of the elements under the Seniors Strategy into one organization, each element had its own objectives. These objectives have since been reviewed and reinterpreted in light of the strategic directions of the DAS and are now incorporated and reflected in the Division's long-term strategic directions. Both the objectives and the long-term strategic directions were developed and introduced in 1994. The long-term strategic directions are:

- ☐ *to improve and preserve the health, independence and well-being of seniors in Canada;*
- ☐ *to increase society's understanding and acceptance of aging and seniors; and*
- ☐ *to eliminate barriers to the involvement and participation of seniors in society.*

In addition to the long-term strategic directions, the Division also has five short-term goals and sub-goals, which are consistent with the Strategy's objectives and are achievable within the life of the current strategy. The first goal is to increase and consolidate knowledge on aging and seniors' issues and to share this knowledge with other federal government departments, the provinces and stakeholders. The second goal is to guide the development of programs, policies and strategies that are innovative, effective and address the needs of seniors and an aging society. This includes providing advice on programs and policies of stakeholders outside the federal

32. Following a reorganization in 1995 in the Policy and Consultation Branch, the name of the Health Policy Division was changed.

government (e.g., professional associations). The third goal is to promote a positive and realistic image of seniors to Canadian society through the Division's activities, communications and educational initiatives. The fourth goal is to provide seniors with the information they need, as well as the opportunity, to make informed choices on issues that affect their health, well-being and independence. The final goal is to provide the National Advisory Council on Aging with the support it requires to fulfil its mandate.

(d) Clientèle and Stakeholders

There are a number of clients and stakeholders that are affected by and benefit from the activities undertaken by the Division of Aging and Seniors including: the federal government, provinces/territories, seniors and seniors organizations, partners in community programming, researchers, NGOs, public/consumers and international clients. In terms of the federal government, the DAS provides the Minister of Health, other Directorates within Health Canada and other federal departments and agencies which have seniors programs (e.g., Human Resources Development Canada) with advice, research findings and forecasts on issues relating to seniors and aging. The Division also provides support (e.g., administration, organizing of events) to the NACA and the SIRP Advisory Committee.

The activities of the Division of Aging and Seniors also extend to the provincial/territorial governments. Through the DAS, partnerships and collaborations on initiatives with the provincial/territorial governments and stakeholders are developed and funding for research and community projects on seniors' issues is provided. In addition, the DAS shares the results of research and policy studies, coordinates national meetings for the purpose of exchanging information and provides support to the Federal/Provincial/Territorial Ministers of Health and Ministers Responsible for Seniors on issues concerning seniors.

The primary external clients and partners of the Division of Aging and Seniors and the Seniors Strategy are seniors and their organizations. The meaningful participation of seniors and their organizations in the activities of the DAS is recognized and clearly stated in the guiding operating principle of the Division:

It is understood that in executing all of its roles and responsibilities, the Division of Aging and Seniors will endeavour to ensure the meaningful participation of seniors in federal decisions and activities that affect them.

The active participation of seniors in federal planning and decision making as well as the ongoing exchange of information is made possible through the DAS which provides a link between seniors and the federal government.

An important aspect of the Division of Aging and Seniors/Seniors Strategy is the formation of partnerships with seniors, NGOs, other levels of government, business and labour. Through partnerships, whether it be financial, material or human resources, the impact of seniors programs on the health, well-being and independence of seniors at risk is expected to be enhanced. Given the impacts of the aging population on Canadian society, partners in community programming are important clients and stakeholders of the DAS/S. Besides forming partnerships and undertaking collaborative initiatives with the DAS/S, NGOs are also involved in the exchange of information with the Division on issues, programs and research regarding seniors and aging. In addition to the partners in community programming, partnerships with researchers, academics, universities, research centres and gerontological associations have also been developed through DAS initiatives such as SIRP.

Through the Division, seniors or their representatives, the media and Members of Parliament can receive information and advice on services, policies and

programs aimed at seniors. In addition to inquiries, the DAS will also respond to complaints regarding seniors programs and services.

As well as seniors programs in Canada, the Division also monitors programs and services offered to seniors in other countries (e.g., United Kingdom, Australia). The DAS also exchanges information with international organizations concerned with aging issues (e.g., the International Federation on Ageing) and represents Canada in international initiatives (e.g., International Year of Older People 1999).

4.2 Program Elements

There are four program elements which comprise the Division of Aging and Seniors/Seniors Strategy: seniors community programs funding; the Seniors Independence Research Program; policy coordination and support to the Minister; and support to the National Advisory Council on Aging. Although each of these elements has their own set of objectives, the activities undertaken to meet the objectives all contribute to the achievement of the Division of Aging and Seniors and Seniors Strategy's goals. Each of these elements is described in detail below.

(a) *Seniors Community Programs Funding*

It is within this program element that the contribution funding programs — New Horizons Program, Seniors Independence Program, Ventures in Independence funding program and New Horizons: Partners in Aging — contained in the community funding profiles of both Strategies have been placed. As noted earlier, the New Horizons program, the Seniors Independence Program and the Ventures in

Independence funding program were merged into the New Horizons: Partners in Aging (NH:PA) program in April 1995. The delivery of the Seniors Community Programs is the responsibility of the DAS and the Health Promotion and Programs Branch Regional Offices (HPPBRO). Following is a discussion of each of these programs.

New Horizons Program

The New Horizons Program was first established in 1972 as a developmental program (Health Canada, 1988). The awareness of Canada's aging population had resulted in increased concern over the rising costs of institutional care and the greater demand for services by and for retired persons. At the same time, it was also being recognized that there was a link between an active and meaningful lifestyle and the maintenance of health and well-being. The original thinking behind the Program was that it would open up opportunities for seniors feeling socially isolated and alone to help each other and their community by becoming involved in social activities. The original objective of the Program in July 1972 was:

to enable retired persons to participate in projects which will engage them in meaningful activities and which at the same time will prove helpful to the community as to other people.

Almost immediately, the Program started down the road of revision and modification. In December of the same year, the objective was modified to reflect the emphasis on funding *groups* of older Canadians:

to enable groups of retired people to participate in activities which are designed to overcome patterns of social isolation of retired people in Canada and which will be beneficial to themselves, other Canadians and the community.

This was not, however, the last time the New Horizons Program objective would be revised. It was modified again in 1975, this time to stress the selection, planning and operation of New Horizons projects by seniors:

to provide meaningful opportunities for retired Canadians to plan, operate and participate in meaningful activities of their own choosing which will prove beneficial to themselves and the community.

Based on this objective, a number of guiding principles were adopted for the management of the Program:

1. Although retired seniors would be responsible for choosing the activities and for their programming, younger people would still be able to participate.
2. As the seniors would be permanently retired, they would not receive salaries.
3. As it is the intention of the program to encourage group activities, only those groups with ten or more people would receive funding.
4. To encourage self-sufficiency, groups would receive funding for only a limited time.
5. All regions would have access to funding throughout the year.
6. Groups would be able to obtain advice and assistance from staff regarding the planning and organization of their activities, resources permitting.
7. Groups would be expected to report on the use rate of funds received.
8. Provinces would have the opportunity to comment on any projects being recommended for funding in their province.
9. Established agencies with salaried employees providing services to seniors would not be eligible for funding.

All applications for funding were evaluated against the eligibility criteria. The types of activities typically funded by the New Horizons program included: sports and fitness (e.g., tai chi); arts and crafts; performing arts and entertainment; history; media; education; service provision; organizational development and research. Fiscal restraints which led to budget cuts in 1987-88 coupled with pressure from the Senate Committee for more service-oriented projects resulted in the development of regional funding priorities, which were established each year, and the approval of more service-oriented projects (Health Canada, 1988). New national priorities were added in 1991-92 which corresponded to priority areas identified by the then Minister of State for Seniors.

Projects received funding for 18 months, although it could be extended for another 18 months. As already indicated, the reasoning behind limited funding was to encourage projects to become self-sufficient. Projects that received funding were monitored and ongoing consultation with field staff was available to assist groups as needed. For evaluation purposes, data on the project were gathered and analyzed.

Outputs of the New Horizon Program included:

- ☐ the general public, senior citizens' organizations, and other government departments and agencies were provided with information regarding the Program;
- ☐ both activity-oriented and service-oriented projects were submitted in all regions across Canada;
- ☐ projects were funded;
- ☐ seniors were involved in the Program; and
- ☐ program reviews and reports were completed.

The primary reporting requirement of New Horizons was the completion of an Activity and Accounting Report. Final Reports were also produced as well as, in most recent years, Evaluation Reports.

On April 1, 1995, New Horizons was merged with the Seniors Independence Program and the Ventures in Independence funding program to comprise the new New Horizons: Partners in Aging program. As noted in the previous section, this merger resulted in a program reorientation (e.g., objectives) and a change in operational modalities (e.g., priority setting process, proposal solicitation, review and approval process).

Since its inception in 1972, the New Horizons program has funded 38,935 projects at a total value of \$256,562,770.64. During this time, the total number of individuals that have participated in New Horizons projects is 5,594,507. Table 4.1 breaks this information down by year.

TABLE 4.1
New Horizons Program
Financial Table
Summary Report
1972 to 1995

Fiscal Year	Allocation	Projects	Participants	Approved	Expenditures
1972-1973	\$6,150,000	493	73,500	\$3,387,631	\$2,145,144.00
1973-1974	8,566,000	1,614	386,634	8,655,656	8,625,427.18
1974-1975	8,566,000	1,549	289,858	8,429,206	8,554,720.00
1975-1976	11,338,000	1,836	207,656	11,455,992	11,338,188.00
1976-1977	11,116,000	1,754	155,797	10,972,900	11,113,147.00
1977-1978	12,216,000	1,841	203,638	12,700,071	12,210,629.00
1978-1979	10,966,000	1,833	193,287	11,125,841	10,965,999.31
1979-1980	10,466,000	1,896	237,980	10,260,653	10,466,000.84
1980-1981	11,788,000	1,933	316,388	12,592,212	11,787,948.75
1981-1982	12,384,000	1,890	290,337	12,342,903	12,381,306.62
1982-1983	12,734,000	2,031	286,645	12,914,685	12,733,794.43
1983-1984	12,734,000	1,999	284,850	13,099,013	12,732,528.05
1984-1985	13,371,000	2,145	256,446	13,328,585	13,371,000.01
1985-1986	13,371,000	1,903	215,962	11,888,896	12,133,536.00
1986-1987	10,000,000	2,029	219,771	9,455,988	9,982,587.24
1987-1988	9,650,000	1,852	203,318	8,771,450	8,742,395.47
1988-1989	11,700,000	1,862	248,463	13,951,038	11,996,881.30
1989-1990	15,000,000	2,081	274,261	16,231,834	16,267,299.58
1990-1991	15,000,000	1,888	251,833	14,118,354	15,293,011.60
1991-1992	15,000,000	1,631	248,287	13,562,315	13,652,010.60
1992-1993	15,000,000	1,543	516,555	14,292,295*	14,138,763.30
1993-1994	13,500,000	1,169	233,041	11,701,114	11,711,001.00
1994-1995	4,583,876	163	NA	3,751,079	4,219,451.36
Total	264,199,876	38,935	5,594,507	258,989,711	256,562,770.64

Notes:

- "Allocation" is the amount of money allocated to the program in a given fiscal year; this amount reflects any upwards or downwards modification of the funding envelope in that given year;
- "Projects" is the number of (new) projects approved by the program in a given fiscal year;
- "Participants" is the estimated number of participants for all (new) projects approved by the program in a given fiscal year;
- "Approval" is the total contribution committed by the program to fund the (new) projects approved by the program in a given fiscal year; this amount will be expended during the given fiscal year and the two-or-three fiscal years following;
- "Expenditures" is the total contribution given by the program for all projects receiving funding in a given fiscal year; this amount funds (new) projects approved in that fiscal years as well as projects approved in previous years and still receiving funding.

Seniors Independence Program

The Seniors Independence Program (SIP) was initiated in April 1988 as part of the first five-year Seniors Initiative. This program was jointly managed by the Social Service Programs Branch and the Health Services and Promotion Branch. Its purpose, as outlined in the conceptual framework, was:

to enable seniors, acting on their own behalf and in collaboration with others, to increase their independence and quality of life.

Achieving independence involves having the right to make ones own choices and to be involved in the decision-making process. Quality of life also involves having the right to make choices and to act independently. It includes material, physical, mental and spiritual well-being which are affected, in part, by an individual's dignity, self-esteem and feeling of being valued by others.

The objectives of the program were as follow:

- *to promote the involvement of seniors in the design and delivery of projects which affect their quality of life and independence;*
- *to encourage and support the self-care and mutual aid effort of seniors; and*

- *to promote the availability and accessibility of resources which support the health, education and social welfare of seniors.*

There were six guiding principles that provided direction for this program:

1. emphasize senior involvement in making decisions that will affect them;
2. give priority to seniors most in need;
3. stress the importance of community involvement through community development and community action;
4. define independence and quality of life using personal and social development terms;
5. contribute to the social change process; and
6. promote lifelong learning and development.

Projects funded under SIP could be either national or regional in scope. Projects were required, however, to involve seniors in the decision-making process. There were two main funding priorities:

1. Seniors most in need — senior women, seniors living in rural and remote areas and less advantaged seniors. SIP differed from New Horizons, however, in that it could provide funding to agencies or organizations that work for seniors and not just groups of seniors.
2. Projects using a community development approach which resulted in seniors being able to identify their own needs.

The main activities undertaken by SIP included:

- Funding time limited projects. Like the New Horizons Program, funding from SIP, although consistently greater in average funding and duration than New Horizons projects, was only for three years.

- ☐ Consulting and collaborating with government departments/agencies and NGOs to coordinate plans, activities and programs.
- ☐ Providing information, advice and expertise.
- ☐ Collecting, analyzing and distributing information about SIP activities and project results.
- ☐ Conducting special activities.

According to the *Conceptual Framework*, which was finalized in December 1990, there were six outcomes which the program strove to achieve:

- ☐ seniors involvement and empowerment;
- ☐ focus on seniors most in need;
- ☐ recognition of seniors by society;
- ☐ partnerships and collaboration;
- ☐ knowledge and skills development; and
- ☐ attitudinal change in society about seniors.

At the end of each SIP project, project sponsors were required to complete a SIP Impact Questionnaire. Additionally, projects were expected to submit a final report and an evaluation.

Table 4.2 presents information on the number of projects, participants and the amount of funding that has been both allocated and expended by year. In total, \$78,234,845 have been expended on 679 projects.

TABLE 4.2
Seniors Independence Program
Financial Table
Summary Report
1988 to 1995

Fiscal Year	Allocation	Projects	Approved	Expenditures
1988-1989	\$16,000,000	78	\$11,724,998	\$2,574,999
1989-1990	20,000,000	251	33,041,929	13,542,387
1990-1991	16,707,600	77	8,610,811	16,668,985
1991-1992	15,383,000	38	6,004,089	14,856,913
1992-1993	13,000,000	67	6,004,727	12,762,109
1993-1994	12,750,000	123	14,445,786	8,270,817
1994-1995	10,124,146	45	5,811,255	9,558,635
Total	103,964,746	679	85,643,595	78,234,845

Notes:

- "Allocation" is the amount of money allocated to the program in a given fiscal year; this amount reflects any upwards or downwards modification of the funding envelope in that given year;
- "Projects" is the number of (new) projects approved by the program in a given fiscal year;
- "Participants" is the estimated number of participants for all (new) projects approved by the program in a given fiscal year;
- "Approval" is the total contribution committed by the program to fund the (new) projects approved by the program in a given fiscal year; this amount will be expended during the given fiscal year and the two-or-three fiscal years following;
- "Expenditures" is the total contribution given by the program for all projects receiving funding in a given fiscal year; this amount funds (new) projects approved in that fiscal years as well as projects approved in previous years and still receiving funding.

Ventures in Independence

Ventures in Independence was introduced in April 1993 when the Seniors Strategy was renewed for a second five-year period. The objective of this program was:

to involve seniors in new partnerships with business, labour and other levels of government to address issues of aging and independence.

Outcomes of Ventures projects included:

- ☐ partnership with the private and public sectors;
- ☐ seniors involvement;
- ☐ projects funded; and
- ☐ reports and evaluations completed.

As with New Horizons and SIP, Ventures in Independence became a part of New Horizons: Partners in Aging in 1995.

Upon completion, Ventures projects were to submit an Impact Questionnaire and Final Report. Evaluation Reports have also been provided.

A total of 29 projects were funded under Ventures in Independence. While \$3,591,978 was allocated to this program, only \$2,158,307 has been expended. Information on projects and finances by year is provided in Table 4.3.

TABLE 4.3
Ventures in Independence
Financial Table
Summary Report
1993 to 1995

Fiscal Year	Allocation	Projects	Approved	Expenditures
1993-1994	\$2,000,000	16	\$2,318,771	\$933,527
1994-1995	1,591,978	13	1,634,999	1,224,780
Total	3,591,978	29	3,953,770	2,158,307

Notes:

- ❑ "Allocation" is the amount of money allocated to the program in a given fiscal year; this amount reflects any upwards or downwards modification of the funding envelope in that given year;
- ❑ "Projects" is the number of (new) projects approved by the program in a given fiscal year;
- ❑ "Participants" is the estimated number of participants for all (new) projects approved by the program in a given fiscal year;
- ❑ "Approval" is the total contribution committed by the program to fund the (new) projects approved by the program in a given fiscal year; this amount will be expended during the given fiscal year and the two-or-three fiscal years following;
- ❑ "Expenditures" is the total contribution given by the program for all projects receiving funding in a given fiscal year; this amount funds (new) projects approved in that fiscal years as well as projects approved in previous years and still receiving funding.

New Horizons: Partners in Aging

On April 1, 1995, New Horizons, the Seniors Independence Program and Ventures in Independence were amalgamated to form New Horizons: Partners in Aging (NH:PA). The amalgamation of these programs resulted in a reorientation of their focus towards funding programs aimed at seniors who are most "at risk", although it is important to keep in mind that the SIP already focused on seniors "most in need".

The purpose of this program, as outlined in the *Conceptual Framework*, is:

*to foster the involvement of seniors and their partners in action
to improve the health, well-being and independence of seniors in
situations of risk or prevent situations which put seniors at risk.*

This purpose can be broken down into three main objectives:

- ❑ to meet the needs of seniors in situations of risk or to prevent situations which put seniors at risk (this is the primary objective of the program which all projects must meet).
- ❑ to find innovative processes and solutions and evaluate and share project results;

- ❑ to build partnerships between seniors and others interested in working on issues that face seniors and an aging society.

The principles upon which this program is based are as follows:

- ❑ *Seniors as Contributors.* Seniors' experience and understanding of the issues which face their peers, particularly those in situations of risk, make them significant contributors to society. Their assistance in meeting program objectives is invaluable.
- ❑ *Reducing Inequity.* By addressing the needs of seniors living in situations of risk or preventing these situations from occurring, this program strives to reduce the inequity of seniors whose health, independence and well-being are being threatened by such situations.
- ❑ *Target Group Involvement.* As it is those seniors living at risk that are the most capable of defining their needs and determining the responses that will best address those needs, it is important to have them actively involved in the program.
- ❑ *Innovation, Learning and Sharing.* New innovative approaches are needed to address the challenges created by Canada's aging population. In addition to developing innovative approaches, it is also important to share the lessons learned from the various projects initiated under the program.
- ❑ *Working Together.* A healthy aging society is not a goal that can be achieved by one group alone. This program realizes that in order to maximize impact on the health, well-being and independence of seniors living in situations at risk, it will be necessary for partnerships between seniors, government, non-government organizations, business and labour to develop.

Funding priorities for New Horizons: Partners in Aging are set nationally and regionally in consultation with seniors, community groups and organizations and government representatives. This process provides stakeholders with the opportunity to refine the Program's definition of situations of risk. By establishing priorities, the program can ensure that funding will be targeted towards those areas where it will have the greatest impact. Although the priorities vary across provinces/territories,

three common issues that have been identified are: seniors who are physically or socially isolated; informal caregiving and the needs of caregivers; and the abuse and neglect of seniors.

The primary activities of this program include to:

- ☐ fund community-based and national projects which target seniors at risk;
- ☐ involve stakeholders in the development of program strategies, including the setting of national and regional priorities;
- ☐ collect, evaluate, synthesize, compile and disseminate all information, products and models which result from program activities;
- ☐ build partnerships between seniors and others interested in working on seniors' issues; and
- ☐ provide advice and expertise on issues related to aging.

The outcomes which New Horizons: Partners in Aging strives to achieve, but to which it is not limited are as follows:

- ☐ contribute to enhancing the health, well-being and independence of seniors at risk;
- ☐ increase the opportunities for the participation and involvement of seniors at risk;
- ☐ contribute to the acquisition of knowledge and skills by seniors at risk which will enable them to speak on their own behalf;
- ☐ increase the number of effective community resources, programs and strategies which address the needs of at risk seniors;
- ☐ increase public awareness of seniors' issues;
- ☐ develop innovative solutions for responding to the needs of seniors at risk;

- ☐ increase knowledge and understanding of seniors' issues and strategies to effectively address them;
- ☐ influence health and social policies, program design and service delivery which are based on the knowledge gained from program activities;
- ☐ develop new and strengthened partnerships and networks to address the issues of at risk seniors;
- ☐ increase the contributions and participation of stakeholders in the development of Program policies and strategies;
- ☐ increase the resources by partners to meeting the needs of at risk seniors; and
- ☐ increase the recognition of seniors as contributors who occupy valued roles in society.

Reporting requirements for the New Horizons: Partners in Aging includes the submission of a Final Report and evaluation.

Financial information as well as the number of projects that have been funded under the New Horizons: Partners in Aging are presented in Table 4.4. As the table indicates, in 1995-96, \$10,885,905 was expended on 143 projects.

TABLE 4.4
New Horizons: Partners in Aging
Financial Table
Summary Report
1972 to 1996

Fiscal Year	Allocation	# Projects	Participants	Approved	Expenditures
1995-1996	\$15,237,000	143	*****	\$6,567,823	\$10,885,905.00
Total	\$15,237,000	143	*****	\$6,567,823	\$10,885,905.00

Notes:

- "Allocation" is the amount of money allocated to the program in a given fiscal year; this amount reflects any upwards or downwards modification of the funding envelope in that given year;
- "Projects" is the number of (new) projects approved by the program in a given fiscal year;
- "Participants" — information on the number of participants is no longer required from project applicants;
- "Approval" is the total contribution committed by the program to fund the (new) projects approved by the program in a given fiscal year; this amount will be expended during the given fiscal year and the two-or-three fiscal years following;
- "Expenditures" is the total contribution given by the program for all projects receiving funding in a given fiscal year; this amount funds (new) projects approved in that fiscal years as well as projects approved in previous years and still receiving funding.

After New Horizons, SIP and Ventures were merged into NH:PA, the three programs ceased to exist while some of their projects were still ongoing. Outstanding commitments, therefore, are coming from the NH:PA allocation. That is:

- \$1,474,824.00 were paid to NH projects in 1995-96, \$771,174.00 are committed to NH projects in 1996-97 and \$7,000.00 are committed to NH projects in 1997-98, for a total of \$258,815,768.60 spent/committed for NH projects approved from 1972-73 to 1994-95;
- \$6,546,055.96 were paid to SIP projects in 1995-96, \$3,696,299.12 are committed to SIP projects in 1996-97 and \$81,019.00 are committed to SIP projects in 1997-98, for a total of 88 \$558,219 spent/committed for SIP projects approval from 1988-89 to 1994-95;
- \$821,897.00 were paid to Ventures projects in 1995-96, \$662,931.00 are committed to Ventures projects in 1996-97 and \$107,162.00 are committed to Ventures projects in 1997-98, for a total of 3,750,297 spent/committed for Ventures projects approved in 1993-94 and 1994-95;
- conversely, NH:PA projects only claimed \$2,007,002 from the NH:PA allocation for 1995-96.

(b) Seniors Independence Research Program

The Seniors Independence Research Program was first introduced as part of the initial five-year Seniors Initiative which was announced in February 1988. While the coordination of this program is provided by the Division of Aging and Seniors, the administration of its contributions are handled by the National Health Research and Development Program (NHRDP). The purpose of the Seniors Independence Research Program is:

to strengthen national research with a balanced emphasis on social, economic and health determinants of independence for both today's and tomorrow's seniors.

An underlying theme of this program is to encourage and promote partnerships not only within the research community, but also between the research community and groups such as seniors, business, non-governmental organizations, voluntary organizations, the health and social services community, and government policy advisors and decision-makers.

SIRP's current priorities include:

- ☐ the encouragement of multidisciplinary research leading to relevant and practical information;
- ☐ the focusing of research on the primary social, economic and health factors affecting seniors' independence;
- ☐ the continued study of dementias such as Alzheimer's disease and the development of research on osteoporosis;
- ☐ the analysis of data from large surveys;

- ❑ the dissemination of research findings from the first and second initiatives and their implications;
- ❑ the monitoring of seniors' health problems and the development of strategies that will reduce their impact; and
- ❑ the strengthening of Canada's capacity in regards to social and health research.

SIRP activities are both numerous and varied. Although the program does provide funding for research activities, it is not strictly a funding program. As the following list of activities illustrates, it is also involved in monitoring activities (e.g., surveillance of diseases), policy and dissemination activities:

- ❑ special competitions through a Program of Applied Research on health, social and economic issues related to seniors' independence on four main themes;
- ❑ special competitions to foster and support research into the health, social and economic aspects of aging including personnel support to agencies to enable them to conduct research on community-based health and social issues related to the independence of seniors;
- ❑ follow-up studies related to the first initiative such as the Canadian Study on Health and Aging which is a collaborative multi-centre study involving 18 centres from all provinces; sponsored by NHRDP and coordinated by the University of Ottawa and the Health Canada Laboratory Centre for Disease Control (LCDC);
- ❑ surveillance, risk assessment and disease control of diseases affecting seniors;
- ❑ workshops, conferences on social, economic and health determinants of independence for both today's and tomorrow's seniors; and
- ❑ implementing effective strategies for the dissemination of the research findings.

There are a number of groups involved in SIRP's activities. Research findings are disseminated through the SIRP Advisory Committee, which includes researchers, seniors' representatives and NGOs. The Extramural Research Division also collaborates actively with this Advisory Committee, as well as being directly involved in the management of SIRP. Other partners in SIRP activities include universities, centres on aging and provincial policy makers.

The SIRP components within the Division are responsible for coordinating the program and for providing the SIRP Advisory Committee with support for its operations. In addition to these responsibilities, the SIRP components are responsible for the surveillance of disease and the risk assessment of activities.

While financial information has been requested from the SIRP, it has not yet been received.

(c) Policy Coordination and Support to the Minister

Policy coordination and support to the Minister was first introduced under the initial Seniors Strategy in 1988, through the creation of the Seniors Secretariat. Additionally, support to the Minister of Health and Welfare was provided by the Seniors Strategy through funds to the new Health Policy Division. These functions were maintained when the Seniors Strategy was renewed in 1993. This program element is responsible:

for providing expertise and leadership on seniors and aging issues, and coordinating Health Canada, other federal government and federal/provincial/territorial initiatives on seniors and aging issues, as well as providing education and information to the public.

In the carrying out of these responsibilities, the policy coordination and support element:

- ☐ provides advice on the needs, priorities and programs related to aging and seniors to the Minister of Health and other federal departments;
- ☐ provides support to the Minister of Health and the Federal/Provincial/Territorial Ministers responsible for Seniors;
- ☐ coordinates and manages Health Canada activities aimed at seniors including the Seniors Strategy;
- ☐ coordinates federal government activities aimed at seniors;
- ☐ develops and coordinates federal policies on aging;
- ☐ coordinates interdepartmental and federal/provincial/territorial shared initiatives; and
- ☐ provides education and information to the public through public education campaigns, the provision of information services and the conducting of communications.

One of the activities that falls under the mandate of this program is the Interdepartmental Committee on Seniors Issues. This Committee was created in 1994 at the instigation of the then Seniors Directorate and Senior Management of the then Health Services and Programs Branch. Membership on this committee is comprised of Assistant Deputy Ministers/delegates from the federal departments and agencies with an interest in seniors' issues (e.g., Transport Canada, Canada Mortgage and Housing Corporation, Department of Indian and Northern Affairs, Industry Canada, Veterans Affairs Canada). This committee meets quarterly and its activities include to:

- ☐ improve the exchange of information on departmental research activities and policies concerning seniors and an aging population;
- ☐ identify emerging priorities and initiatives;

- ☐ identify and increase opportunities for bilateral or multilateral collaboration;
- ☐ share results of innovative initiatives; and
- ☐ provide input for Federal/Provincial/Territorial meetings of Ministers Responsible for Seniors.

(d) National Advisory Council on Aging

The National Advisory Council on Aging (NACA) was initiated in 1980 in response to a recognized need by the then Minister of Health and Welfare for independent advice and research on aging and seniors' issues. Research and Secretariat support is provided to the Council by the DAS. This Council is comprised of up to 18 members from all parts of Canada and all walks of life. They are appointed by Order-in-Council for two- or three-year terms which can only be renewed once. The primary responsibility of NACA is:

to assist and advise the Minister of Health on all matters related to the aging of the Canadian population and the quality of life of seniors.

It carries out this responsibility by providing recommendations on current and upcoming priorities that are well thought out and timely. It also undertakes activities that reinforce its advisory capacity. NACA activities include:

- ☐ reviewing the needs and problems of seniors and recommending remedial action by consulting seniors and experts, monitoring policy developments in Canada and abroad, conducting documentary research and qualitative and quantitative analysis and by selecting the best policy and program alternatives;
- ☐ maintaining contact with national, provincial and local associations, institutions and groups involved in aging or representing seniors;

- ❑ distributing information through a mailing list of interested individuals and organizations, appearing before parliamentary committees, exhibiting material at conferences and answering individual requests;
- ❑ publishing reports, such as *NACA Position Papers*, *Expression*, *Info-Age*, *Writings in Gerontology*, *Forum Collection Papers*, *Challenge Papers*; and
- ❑ stimulating public discussion on aging by organizing panel discussions and workshops, promoting special events and initiatives through press releases, submitting articles to newspapers and professional journals and by cooperating with the media to create a greater national awareness of aging issues.

NACA's activities have resulted in a number of outcomes. Following are some of their activities' outcomes and end products since 1993 (The National Advisory Council on Aging: A Retrospective from 1993 to 1996):

- ❑ policy recommendations on women's life-course, long-term care and medication use, community services in health care for seniors, priority setting in health care, technology in health care, retirement income and pensions, and the Canada Pension Plan;
- ❑ effective coverage of seniors' issues through NACA's continued contact with seniors and seniors-related organizations as well as its close collaboration with informed contacts at the national, provincial and local levels;
- ❑ raised the understanding and debate on questions such as atrial fibrillation, aboriginal seniors' issues, family relationships, and inappropriate medication use; and
- ❑ information has been disseminated through published documents such as *NACA Position Papers*, *NACA Briefs*, *Writings in Gerontology*, *Forum Collection*, *Aging Vignettes*, *Expression*, and *Info-Age*.

CHAPTER

5

FILE REVIEW

This chapter provides an overview of the administrative data bases utilized by the DAS and presents the findings of the project file review conducted to date. A review of project files was conducted to provide data on the activities and outputs of the projects within each of the program elements. For the purpose of the evaluation and hence, of this review, only projects undertaken in the past five years were examined. Although a review of project files from all program elements is to be conducted, to date only project files from the Seniors Community Funding Programs have been reviewed. Consequently, for this report, the analysis will only pertain to the projects within this program element. The remaining project file review components will be discussed in the Second Interim Report.

5.1 Collection of Data

In order to facilitate the collection of data, a data collection form was developed (see Appendix B). The design of the data collection form was based on a careful review of all the evaluation issues and indicators which were proposed to address each of the evaluation issues. This clear and precise specification of the types

of information to be collected was critical to ensure that the appropriate data were collected and the file review collected similar information, to the extent possible, across all program elements. In order to make the analysis of the information easier and to save time, the guide was put into the Computer Assisted Telephone Interviewer (CATI) program, meaning that a data base was automatically created as the information was entered.

As already stated, the files reviewed for this report pertain solely to Seniors Community Funding Program projects. Once the data collection instrument was in place, a review of a sample of Seniors Community Funding Programs was undertaken to determine the sort of documents retained in the files and to select which of these should be requested from the Regional Offices. It is important to note that it was known that not all documents requested would necessarily be available for all projects. Following this preliminary review of files, the following documents from community funded programs were requested (and obtained) from the regional offices as well as the national office (i.e., DAS):

- ☐ Funding Approval Form;
- ☐ Applications (if available);
- ☐ Activity and Accounting Reports (for New Horizons projects);
- ☐ Impact Questionnaires (for SIP and Ventures projects);
- ☐ Interim Reports (when final reports were not available, such as when the project was not yet completed);
- ☐ Quarterly Narratives (when final reports were not available, such as when the project was not yet completed);
- ☐ Final Reports (for completed projects for which this was a requirement, i.e., NH:PA, SIP); and
- ☐ Evaluation Reports (for completed projects for which this was a requirement, i.e., NH:PA, SIP).

In addition to these documents, information was also requested from the Contribution Information System (CIS). The information requested included:

- ☐ project number;
- ☐ duration of the project;
- ☐ funding priorities;
- ☐ subject codes;
- ☐ total amount of dollars committed;
- ☐ other financial support; and
- ☐ in-kind support.

It was originally anticipated that "funding priorities" and "subject codes" could be used to help determine the target group of the project and whether the issues that the project was focusing on pertained to health and well-being, independence, attitudes towards aging or barriers to participation. When an attempt was made to collapse the codes within each of the indicators, however, it was soon discovered that these codes could not be used for this purpose. Given that the issues of health, well-being and independence are so broad and so inextricably intertwined, any given code could be relevant to any or all of the issues. This opinion was confirmed by the DAS who indicated that previous attempts to collapse these codes had been unsuccessful. The "other financial support" and "in-kind support" indicators were also not very useful due to contradictory information in the files. In terms of financial contributions, for example, in many cases contributions noted in the files were not noted in the CIS. This lack of information is partly due to the fact that the inputting of this information had not been a priority. Additionally, according to the CIS, financial contributions were often listed as an in-kind contribution. For the purpose of this project, however, financial contributions were considered as sources of funding and not as in-kind contributions.

There was also at times a contradiction between the files and the CIS on the amount of funds received from the DAS. This contradiction, however, can be explained in part by reviews and revisions to the original applications, project funding amendments and refunds made by project sponsors after project completion. In the end, "project number", "duration of the project" and "total amount of dollars

committed" were the indicators chosen for use. Of note is that this information was not available from the CIS for 29 of the New Horizons projects sampled in the 1991-92 and 1992-93 time periods.

Definitions

The actual review of the files required the analysts to make a number of subjective decisions, particularly in terms of determining which issues³³ to the project was addressing and who were the clients of the projects. As analysts were working fairly independently and needed to feel confident regarding their coding for each file, certain definitions were developed to ensure, as much as possible, that items were being coded consistently across all analysts. Following are the definitions that were arrived at and used throughout the file review exercise:

- ❑ **Health and Well-Being.** A project was coded as addressing health and well-being if its activities were aimed at, for example, seniors with chronic illnesses, physical disabilities, mental-illness, socially isolated seniors and seniors' general health. For example, a meals-on-wheels program aimed at preventing seniors from falling into the "tea and toast" spiral by providing seniors with nutritious meals would be coded as addressing health and well-being.
- ❑ **Independence.³⁴** Defining independence separately from health and well-being was a challenge as the three are so inextricably intertwined. The decision to separate independence from health and well-being was

- 33. Health and well-being, independence, attitudes towards aging and barriers to participation are issues of concern to seniors community funding programs. As such, the addressing of these issues are evident in project objectives and priorities. They are also "needs" of seniors. For the purpose of the file review they are referred to as "needs".
- 34. It should be noted that the Division finds our definition of independence to be very narrow. They find the definition fails to include the concept of autonomy and cannot appreciate nor envision independence within a nursing home or institutionalized setting. This definition could result in findings pertaining to community projects not addressing independence as having limited validity.

one that was strongly discouraged by the DAS during the design phase. We felt, however, that some delineation was important to attempt in order to be able to discuss differences among the various funded projects. Having separated the concept of independence, however, necessitated that a definition be developed. The Division of Aging and Seniors and Seniors was asked for a definition of independence, but, as they do not separate the three concepts, felt unable to respond to our request.

There is not a simple definition of independence as it refers to seniors. According to the Conceptual Framework for the Seniors Community Programs (1993), seniors independence is a continuing process involving a balance between self-reliance, interdependent relationships and support from others. Additionally it involves the right to make choices, act on one's own behalf and be involved in decisions affecting oneself. Another report indicated that seniors independence requires ensuring: the necessities of life, including adequate income, access to health care and housing; access to work or income generating opportunities; timely access to community support services; access to education and training programs; and access to health promotion/illness prevention activities (Cambium Consulting, 1991). Not all aspects of the above definitions/requirements can be easily operationalized. It was still important, however, to develop a definition to ensure this item was being coded consistently by the analysts.

It was finally decided that a project would be coded as addressing independence if its activities were aimed at enabling seniors to remain within the community by, for example, not only having services and activities available but also by having them be accessible (e.g., through transportation). This definition provided analysts with a mere guideline. Additionally, inherent in the word "independence" is "lack of dependency". Consequently, projects whose activities were clearly aimed at reducing a senior's dependency would also have been coded as addressing the issue of independence. For example, a project in which volunteers assisted seniors with their grocery shopping would be considered addressing the issue of independence by not only relieving that senior's dependency on family and friends for their grocery shopping, but by giving them some control over what they buy.

Finally, projects which clearly stated *how* they were addressing seniors independence would have been coded as addressing independence. As the question on addressing independence, as well as the questions on health and well-being and eliminating barriers, was an open-ended question on the data collection instrument and not a simple yes or no,

it was important to know *how* a project was addressing this issue. In order to continue on to the next question/item, the analysts would have to explain how a project was addressing independence.

In instances where health and well-being played a role in addressing seniors independence, this would have been captured in one of two ways. The project would be coded as addressing health and well-being as well as independence or the health and well-being factor would have been noted in the explanation of how the project was addressing independence.

- ❑ **Target Group.** The target group was identified as those people who were the ultimate beneficiaries of the project, that is, the group whose needs the project was/is attempting to address. Although for all projects seniors or a subgroup of seniors would be targeted, some projects would also target other groups such as youth or caregivers.
- ❑ **Clients.** The clients were considered to be those people who would benefit from the project, but were not necessarily the target group. For example, in a project that provides information to professionals within the community to help them better address the needs of the seniors they serve, the professionals would be considered to be the client. In those cases where a project is providing direct services to a target group, the target group would also be considered to be a client.

Caveats

Reviewing project files of programs within initiatives such as the Division of Aging and Seniors/Seniors Strategy is difficult as each program has its own objectives and requirements. To add to this difficulty is the evolution through which some of the programs have undergone resulting in changes in objectives and requirements during the five-year timeframe for the evaluation. The difficulty is enhanced when past project files are reviewed in light of current objectives and requirements. Innovation, for example, is a current requirement of Seniors Community Programs Funding. Consequently, the innovativeness of newer projects is clearly stated in the project files. In comparison, early projects were not required to be

innovative and so, although they may have been innovative, this information is not typically presented in the files.

An additional problem with reviewing project files is that the files do not tend to be maintained with the idea that they will be reviewed as part of an evaluation a few years down the road. Even if an attempt was made to maintain files in light of a potential evaluation, it would be difficult to know what information would be relevant at that time. Consequently, aspects of projects which are defining characteristics or otherwise assumed (e.g., the use of volunteers in New Horizons projects) may not be recorded in detail in the files (e.g., how many volunteers were involved in the project).

In instances where information was not available, but for which we felt could be potentially true of the project (e.g., it was innovative in some way, volunteers may have been involved), the question was coded as "information not in file" as opposed to "no".

Given the above, the primary constraint in reviewing the project files was the time available for the analysts to review the files. The budget for this component of the evaluation was extremely modest. Analysts had less than a half an hour within which to review each project file. In order to make this time as productive as possible and to ensure that as much information was gleaned from the files as could be, time was spent to carefully develop a data collection form. Additionally, a preliminary review of a sample of community funded projects was undertaken to ensure that the documentation requested for the project files would be the most likely to provide us with the necessary information to complete the data collection form. While the data collection form provided very specific guidance on the types of information to be collected to ease the data collection process, a comprehensive review of the documentation provided was not possible. The fact that most of the information

provided in the files was qualitative made the review of files within the allotted time period particularly challenging. The time spent upfront in developing a data collection form that was as focused as possible, however, ensured that the most useful information was obtained. Thus, while the file review did not entail a detailed review of everything in each project file (which was never the intent), it allowed for the collection of information related to central evaluation questions on a large number of varied projects.

Another major barrier to the file review was the lack of documentation in terms of final reports and evaluations (e.g., completed SIP Impact Questionnaires). While this was not necessarily a failing on the part of the projects (i.e., not all programs required a final report or evaluation, some projects had just been completed, some projects were on-going), this lack of documentation made it difficult to comment on impacts and effects and strengths and weaknesses of projects. Although the information provided in the proposals, applications and funding approval forms could provide insight into what the *expected* impacts and effects would be, the purpose of the file review was to comment on *actual* impacts and effects.

Data Quality Assessment

Given the limited time frame for conducting the review of the files, it is difficult to accurately comment on the quality of the data contained in the files. Information may have existed which was not revealed because a comprehensive review of all documents was not possible. Based on the information requested, however, there were a few weaknesses in the files.

- ❑ ***Evaluations.*** For those projects for which evaluation information was available (e.g., SIP Impact Questionnaires), this information was primarily subjective in nature and qualitative. In instances where

numbers were provided (e.g., Evaluation Reports), there was often only very limited analysis of their meaning.

- ☐ **Volunteers.** Information contained in the files on volunteers was not always provided in sufficient detail. For example, although it may be evident that volunteers were involved in a project, the actual number of volunteers was often missing.
- ☐ **Contributions of partners.** While many of the project files enumerated the partnerships which had been established and the contributions of the partners, others either simply alluded to the fact that there were partners or did not provide specific information as to the specific role of each partner.
- ☐ **CIS administrative system.** There is a lack of information in the CIS administrative system on projects undertaken prior to 1993, with the exception of SIP projects. This is primarily due to the fact that the CIS was only initiated in 1993 and prior to that there were a number of different systems being used. Consequently, the CIS is not a useful source of information for obtaining insight into projects that were undertaken prior to 1993.

5.2 Administrative System Information

The Division of Aging and Seniors utilizes two main administrative systems. The first is the Contribution Information System (CIS) which contains information on the Senior Community Funding Program's projects. Prior to 1993, there were several different systems being used and so, although the CIS contains complete information on the Seniors Independence Program from 1988 as well as on Ventures and NH:PA, information on projects funded under New Horizons are incomplete until after 1993. The CIS is a comprehensive data base and contains the following types of information on each project:

- ☐ project number;
- ☐ project title;

- ☐ name and address of the applicant;
- ☐ contact name, address and telephone number;
- ☐ start date and end date (original and current);
- ☐ duration of the project (including extensions);
- ☐ financial commitment from the DAS;
- ☐ financial contributions from other sources;
- ☐ project costs;
- ☐ in-kind contributions (type and value);
- ☐ project funding priorities;
- ☐ project subject matter;
- ☐ project description;
- ☐ due dates of reports;
- ☐ reports received to date;
- ☐ date of on-site visitations; and
- ☐ reviewers' comments.

The CIS also records payment information and is used to initiate the payments. It should be noted that not all this information is necessarily kept for each project.

The CIS administrative system was used to sample projects for the file review and to obtain financial information regarding funding from the DAS for each project sampled.

The second administrative system used by the DAS is the Seniors Inquiry/Tracking System (SITS). This administrative system, which was instituted in 1994, contains records for DAS files and correspondence (including NACA and Ministerial correspondence) since 1994-95. Table 5.1 is an example of the types of files contained in the SITS and the corresponding number of communications per file.

TABLE 5.1
Files in the Seniors Inquiry Tracking System (SITS)
September 1995 to March 1996

File Type	Number
All files in SITS	356
All files pertaining to enquiries/correspondence from the public	315
All files pertaining to correspondence initiated by the Division	41
Correspondence (responses by the Division) and responses on behalf of NACA and Minister)	240
Phone enquiries from public	50
Memoranda initiated by Division	33
Fax enquiries from public	15
Correspondence initiated by Division	8
E-mail enquiries from public	7
In-person enquiries from public	3

In addition to the two administrative systems described above, the DAS also has an electronic filing system. This filing system contains a record of all correspondence files pertaining to the Division (i.e., Division correspondence, correspondence written on behalf of the Minister or NACA). Table 5.2 presents correspondence records found in the electronic filing system.

TABLE 5.2
Records in the Division's (Electronic) Filing System
April 1994 to the Present*

Record Type	Number
All correspondence records in filing system	1,223
Records pertaining to Division correspondence**	567
Records pertaining to correspondence composed on behalf of the Minister	521
Records pertaining to correspondence composed on behalf of NACA	135

* Based on the records in the Division's computerized filing system, which reflects the physical files themselves. The contents of this filing system are supposed to date back to the creation of the Seniors Directorate (April 1994), but it is possible that some files in the system predate this.

** Responses to enquiries from the public comprise the vast majority, if not almost all, of the Division correspondence.

5.3 Project File Review

(a) Seniors Community Funding Programs

There are four programs which fall under the Seniors Community Funding Programs: New Horizons; Seniors Independence Program; Ventures in Independence; and New Horizons: Partners in Aging. As each of these programs has its own specific objectives, each program will be analyzed separately. Also, due to the changes that these programs have undergone since their inception, a comparison of projects within each program will be done by year. It is necessary to note at this point that, due to the small sampling sizes in each year period, once the analysis of a program is broken down into the year categories, the cell sizes become very small. Hence, small percentages only reflect the findings of a very small number of projects

(e.g., in some cases five per cent represents one project). Table 5.3 presents a breakdown of the project files reviewed by program type and year. It also provides information on the number of projects sampled as well as the total population of projects.

TABLE 5.3
Distribution of Projects

	1991-92	1992-93	1993-94	1994-95	1995-96	Overall (91-96)
Seniors Community Programs Funding						
New Horizons: Partners in Aging (n=143)						
Population					143	143
Sampled	-	-	-	-	45	45
Reviewed	-	-	-	-	42	45
New Horizons (n=4,506)						
Population	1631	1543	1169	163	-	4506
Sampled	20	20	45	45	-	130
Reviewed	20	19	45	45	-	129
Seniors Independence Program (n=273)						
Population	38	67	123	45	-	273
Sampled	10	10	30	20	-	70
Reviewed	10	9	30	18	-	67
Ventures in Independence Program (n=29)						
Population	-	-	16	13	-	29
Sampled	-	-	10	10	-	20
Reviewed	-	-	10	8	-	18

New Horizons

The New Horizons Program, which was initiated in 1972, is the oldest of the Seniors Community Funding Programs. It has also undergone the most change. In the analysis of the results of the project file review for this program, comparisons will be drawn among the four years for which projects were reviewed. A total of 129 projects were reviewed (20 from 1991-92, 19 from 1992-93, 45 from 1993-94, 45 from 1994-95), 117 of which were completed and 11 which are ongoing. There was one project for which it was not known whether the project was completed. Overall there was little difference in the average duration of projects within the different years. In 1991-92 and 1992-93, the average duration of projects was 16.6 months and in 1992-93, the average duration of projects was 15 months. Projects undertaken in 1993-94 were a bit longer in duration than the other years, lasting 20.8 months on average.

Overall, the majority of New Horizons projects have focused on seniors' health and well-being (89 per cent). The next most frequently addressed need is barriers to seniors' participation in society (36 per cent) followed by seniors independence (33 per cent). In comparison, only 10 per cent of all projects reviewed address attitudes towards seniors. When these needs addressed are broken down by year, however, some interesting trends appear. As Table 5.4 shows, while health and well-being remain a priority need throughout the four years, there is more emphasis placed on independence and barriers to participation in the later years, with increased emphasis on independence being the most dramatic. Conversely, there is less emphasis on attitudes towards seniors in the later years. Of importance here is that barriers to independence and attitudes towards aging are objectives that were created and "operationalized" after the Seniors Directorate was formed. These objectives were developed during the strategic planning of the new Directorate as an articulation and confirmation of the various objectives of the Strategy elements/components merged

into the Directorate. Consequently, these objectives were complimentary to and supportive of the objectives of New Horizons, but were not specific objectives of this program *per se*. The emphasis being placed on barriers to seniors' participation, particularly in the later years, is a demonstration of the contribution from the New Horizons projects to the objectives of the DAS.

TABLE 5.4
Needs Addressed by the New Horizons Program

Need	Total	1991-92	1992-93	1993-94	1994-95
	Percentage of Projects				
Health and well-being	89	90	84	91	89
Independence	33	5	11	11	56
Attitudes towards aging	10	5	26	11	4
Barriers to participation in society	36	25	26	40	40
Other	16	10	11	16	22
n	129	20	19	45	45

Mental or emotional well-being is the most common health and well-being need addressed by New Horizons projects across the four years (70 per cent, 79 per cent, 87 per cent and 56 per cent¹ respectively). For the first three years, the next most common need to be addressed is physical well-being (50 per cent, 37 per cent and 51 per cent respectively). Although emphasis is also placed on this issue in the fourth year (29 per cent of projects), there was slightly more emphasis placed on poor nutrition (31 per cent). Due to the small cell sizes, it is not possible to draw any comparisons on specific needs addressed under either independence or barriers to participation across the four years. It can be noted, however, that meals provided to seniors in their homes was the most common need addressed under independence in 1994-95 (20 per cent) and the need for more activities/facilities to enable seniors to

participate in the community received the most focus under barriers to participation in 1992-93 (29 per cent).

Over the four year time period under study, the majority of New Horizons projects targeted seniors in general (67 per cent)³⁵. Of interest, however, is the dramatic decrease in projects targeting seniors in general and the corresponding increase in projects targeting seniors at risk in 1994-95 as outlined in Table 5.5. This change reflects the evolution of the program's focus over time towards seniors in situations of risk. While the focus on seniors in conditions of risk began to pick up with the renewal of the Strategy in 1993, it was not until 1994-95 that this focus became fully in effect. In 1994-95, seniors at risk most often targeted were socially isolated seniors (53 per cent) followed by the chronically ill (31 per cent).

Table 5.5 also shows the primary client group of the New Horizons' projects over the first three years to be seniors in general (76 percent). Again, as with the target group, this changes dramatically in 1994-95. In 1993-94, only 16 per cent of projects had seniors at risk as clients and by 1994-95 this had increased to 71 per cent. Likewise, the number of projects with seniors in general as clients decreased from 96 per cent in 1993-94 to 47 per cent in 1994-95. As with the target group, were most likely to be socially isolated seniors (33 per cent) followed by the chronically ill (24 per cent).

35. As projects can target more than one group, the percentages presented will not equal 100.

TABLE 5.5
Target Group and Clients of the New Horizons Program

	Total	1991-92	1992-93	1993-94	1994-95
Percentage of Projects					
Target Group					
Seniors in general	67	80	90	87	31
Seniors at risk	49	15	21	33	91
Other groups	11	5	11	18	7
n	129	20	19	45	45
Clients					
Seniors in general	76	85	90	96	47
Seniors at risk	34	15	16	13	71
Other groups of seniors	4	5	-	2	2
Other groups	9	5	-	-	25
n	129	20	19	45	45

The types of activities undertaken by the projects varied, particularly in 1994-95. The majority of projects over all four years, however, provided services to seniors (80 per cent, 74 per cent, 89 per cent and 76 per cent respectively). It is not possible to comment on project activities by type of activity as the numbers are too small to have any real meaning.

New Horizons projects did not appear to be innovative, particularly in the first two years reviewed for this study. This is not surprising given that, according to the original program design, projects were not necessarily expected to have an innovative aspect. Although this does not mean that projects were not innovative, it means that this information was probably not captured in the files. While there are more innovative projects noted in the final year, 1994-95, this never reaches more than

three projects on any one indicator (n=7) of innovation (e.g., addresses a new issue, takes place in different milieu).

It is important to note that unless it was specifically stated that a project was innovative in some way or it was clear to the reviewer that the project was either innovative or not, these questions were coded as "information not in file". Consequently the extent to which projects were innovative may have been underestimated.

The amount of money received or committed to individual New Horizons projects varied little among the first three years under review. There was, however, a significant increase in the amount of funding provided in the last year. The means and ranges for the four years are presented in Table 5.6.

TABLE 5.6
Financial Contributions from the DAS to Individual NH Projects

	Mean	Range
1991-92	\$8,544	\$2,500 - \$26,540
1992-93	\$9,570	\$1,359 - \$38,660
1993-94	\$10,032	\$1,200 - \$39,849
1994-95	\$18,139	\$1,750 - \$170,440

There is no indication in the files that any New Horizons projects received funding from any other source. It should be noted, however, that it is not a requirement of New Horizons projects to seek other funding sources. As such, this information was not requested from the applicants.

Just under half of the New Horizons projects (40 per cent) indicated also having received in-kind contributions and projects undertaken in 1992-93 and 1993-94 were the most likely to report in-kind contributions (47 per cent and 58 per cent respectively). Comparatively, 35 per cent of projects undertaken in 1991-92 and 22 per cent undertaken in 1994-95 indicated having received in-kind contributions. In-kind contributions noted include human resources, office space, materials, refreshments and office equipment. Values for in-kind contributions were only available for three contributions made in 1993-94. These contributions ranged from \$80 to \$5,000, averaging at \$2,083.

While not all projects under New Horizons were designed to be self-sufficient or on-going, those that did plan to continue past their DAS/S funding needed to access other sources of funding if continued funding was required. Of the New Horizons projects reviewed, the majority indicated plans to continue their activities once funding ended (71 per cent). When broken down by year, a trend emerges where the tendency for continuance increases each year until 1993-94 (75 per cent, 79 per cent and 87 per cent respectively). This trend, however, reverses in 1994-95 when the percentage of projects indicating continuance decreases to 49 per cent. This decrease may be partly explained as many projects were ongoing (17 per cent of projects reviewed for that year) and continuance was not yet known. The sources of new funding indicated by those projects who would require funding varied greatly and included sources such as:

- ☐ fund raising activities;
- ☐ municipalities;
- ☐ community agencies;
- ☐ fees;
- ☐ grants;
- ☐ provincial support; and
- ☐ volunteers.

There was very little information on the dollar amount of the funding provided by these other sources after the Health Canada funding expired. In 1991-92, funding valued at \$5,000 was provided for one project, in 1992-93, one project indicated having ongoing funding in the amount of \$3,000 and in 1994-95, \$800 of funding was noted for one project. Four projects in 1993-94 reported funding amounts ranging from \$300 to \$4,000 and with an average of \$1,289. Of those projects which indicated that continuance was not a goal of the project (41 per cent), only seven per cent (nine projects) indicated having led to ongoing activities.

Partnership development has been limited in the New Horizons projects which can be explained by the fact that partnership development was not an objective or requirement³⁶. Over half of the projects did not involve partners (59 per cent): no partnership development was undertaken in 1992-93 and only five per cent or one project in 1991-92 and 15 per cent or three projects in 1993-94 having developed partnerships. In comparison, 62 per cent of projects in 1994-95 developed partnerships. This increase reflects the fact that partnership development became associated to New Horizons with the full implementation of Seniors Community Funding Programs. Table 5.7 presents the breakdown of the types of partnerships for 1994-95. Due to the fact that partnership development prior to 1994-95 was extremely limited, tables were not created to illustrate partnership development as they would be of little value. As a number of the cell sizes were very small, the purpose of this table is merely to give the reader an overall sense of with whom or what kind of organizations partnerships tended to be developed and in what capacity. As the table indicates, the majority of partnerships in this year were developed with local NGOs (50 per cent) followed by seniors organizations (35 per cent) and regional NGOs and the provincial/territorial government (both at 32 per cent). With the exception of the provincial government, whose primary involvement in the projects tended to be through financial

36. Partnership development does not include partnership with Health Canada's funding program.

contributions, most partners were involved either as an advisory body or provided human resources.

As will be noted, a number of the activities of partners were categorized under "other". These activities included: training and assessment of equipment; dissemination of materials produced; recruiting seniors; media campaigns; and monitoring of projects. In terms of partners which fell into the "other" category, these partners include: municipalities; hospitals; media; community health centres; churches, police departments and industry associations. Unfortunately for some cases, although the files indicated that the partnership existed, there was no information provided as to the capacity in which the partner was involved.

Volunteers are an important part of *all* New Horizons projects. Unfortunately, while this fact is recognized by the analysts, project files did not provide detailed enough information to accurately capture this. Consequently data on this item could only be captured for a limited number of projects:

- ☐ four in 1991-92;
- ☐ two in 1992-93;
- ☐ ten in 1993-94; and
- ☐ nine in 1994-95.

TABLE 5.7
Partnerships — 1994-95
(n=28)

Type	% Projects	New Partnership	Joint Decision-Making	Advisory Body	Shared Facilities	Financial Contributions	In-Kind Contributions	Materials	Human Resources	Other	Information Not in File
Federal gov't	-	-	-	-	-	-	-	-	-	-	-
Provincial gov't	32 (n=9)	-	-	11	-	78	-	-	11	-	11
National NGOs	18 (n=5)	-	-	80	20	-	20	-	20	20	40
Regional NGOs	32 (n=8)	-	11	78	-	11	11	11	33	11	44
Local NGOs	50 (n=14)	29	7	21	21	7	-	-	14	29	21
Seniors organizations	36 (n=10)	-	-	20	20	-	10	10	20	20	20
Universities	4 (n=1)	-	-	-	-	-	-	-	-	100	-
Centres of Gerontology	4 (n=1)	-	-	100	-	-	-	-	-	-	-
Independent researchers	-	-	-	-	-	-	-	-	-	-	-
Business	7 (n=2)	-	-	-	33	33	-	33	-	-	-
Other Partners	32 (n=9)	-	-	-	-	-	-	-	-	-	-
Other partner 1	89 (n=8)	-	-	22	44	22	-	-	-	-	22
Other partner 2	11 (n=1)	-	-	100	-	-	-	-	-	-	-

While there appears to be a substantial increase between 1992-93 and 1994-95, the percentage of projects that these numbers represents is similar. The actual number of volunteers which participated did vary quite substantially between some of the years. The average number of volunteers in 1991-92 and 1993-94 were similar (34 and 33 respectively). In comparison, the average number of volunteers in 1992-93 was 18 and the average number of volunteers in 1994-95 was 54.

Just over half of the New Horizons projects reviewed (59 per cent) indicated specific outputs and results (e.g., publications produced, workshops conducted). For a high percentage of projects (40 per cent), however, there was no information available in the files reviewed to indicate if there had been any outputs or results. Not surprisingly, projects undertaken in 1994-95 were the least likely to indicate outputs (47 per cent). Some of these projects would have just been completed and so files may not yet be finalized and others may still be ongoing. Of interest, however, is that only approximately half of the projects reviewed for the first two years (50 per cent and 53 per cent respectively) indicated outputs. As 78 per cent of projects in 1993-94 indicated having outputs, the smaller percentage in the first two years may be the result of the lack of complete information in the files for review in those two years. Despite the relatively high percentages of projects indicating having outputs in each year, when the outputs are broken down into specific types the number of outputs by type per year becomes too small to comment on. Following are the outputs of the New Horizons projects overall:

- ☐ 87 per cent provided services to seniors;
- ☐ 10 per cent conducted workshops;
- ☐ seven publications have been published;
- ☐ three per cent resulted in policies being developed;
- ☐ one per cent (or one project) conducted a round table;
- ☐ one per cent (or one project) produced educational materials; and
- ☐ one per cent (or one project) provided advice to programs or policies.

In addition, one of the 1991-92 projects and two of the 1994-95 projects resulted in new non-DAS/S projects being initiated.

Information on the number of clients (including seniors and non-seniors) and the number of seniors (as a sub-set of clients³⁷) served was readily available in most of the files reviewed. As with outputs and results, the least complete information comes from files reviewed from 1994-95. Table 5.8 provides a breakdown of the proportion of projects per year with information on clients and seniors as well as the average numbers for each year. Of note is that, on average, there were more clients and seniors being served in 1993-94 than in any other year.

TABLE 5.8
Clients and Seniors Served by Projects Under New Horizons

	Total	1991-92	1992-93	1993-94	1994-95
<i>Percentage of Projects</i>					
Clients	97	85	79	93	51
Seniors	100	90	79	93	56
n (projects)	129	20	19	45	45
<i>Average Number of Clients and Seniors</i>					
Clients	709	106	155	280	168
Seniors	1353	92	233	639	389
n (projects)	129	20	19	45	45

As final reports or evaluations were not required for New Horizons projects, there was little information in the files on impacts and effects of the projects.

37. As will be noted, the average number of seniors is higher than the average number of clients for three of the years. The reason for this is that information on both clients and seniors was not available in all project files. In some projects, only information seniors was provided.

There were, however, impacts noted in five projects (one in 1991-92 and four in 1994-95). These impacts include:

- ☐ a network with over 100 names of parents and children (including seniors) with developmental disabilities was created;
- ☐ social interaction among seniors has been increased;
- ☐ through the help of Seniors, youth and young Aboriginal adults have learned the traditional songs and dances;
- ☐ a grocery store made modifications recommended by the research;
- ☐ community expectations have increased; and
- ☐ seniors are more active.

One unplanned effect from a project undertaken in 1991-92 was also noted:

- ☐ seniors other than the target group have started participating in the project.

Seniors Independence Program

A total of 67 projects funded by the Seniors Independence Program were reviewed for the purpose of this evaluation. They occurred or were approved between 1991 and 1995.

As explained earlier, four categories of needs were distinguished for this file review. Needs related to health and well-being, independence, attitudes towards aging, barriers to participation in society were distinguished and the activities as described in the files were examined to see if they addressed needs related to these categories. As presented in Table 5.9, most financed projects were intended to address health and well-being needs: between 1991 and 1995, 71 per cent were related to health

and well-being. The other categories received less attention, as indicated in the table: between 15 and 25 per cent of projects addressed needs related to attitudes, barriers to participation in society and/or independence. Only one project out of four was found to concern seniors' independence. This may be explained by the strict definitions of the "needs" categories used for this review (see methodology). The percentage of projects dealing with independence, however, has increased over the years, going from 10 per cent in 1991-92 to 50 per cent in 1994-95.

TABLE 5.9
Needs Addressed by the Seniors Independence Program

Need	Total	1991-92	1992-93	1993-94	1994-95
Percentage of Projects Addressing Indicated Needs					
Health and well-being	71	70	66	70	78
Independence	26	10	22	20	50
Attitudes towards aging	16	20	22	10	11
Barriers to participation in society	24	30	22	17	28
Other	47	40	67	37	44
n	67	10	9	30	18

The target groups (i.e., the groups who will eventually benefit from the projects) are presented in Table 5.10³⁸. As shown, most projects are oriented towards seniors at risk while little more than half were targeted towards seniors in general.

38. As projects can target more than one group, the percentages will not equal 100.

TABLE 5.10
Target Group and Clients of the Seniors Independence Projects

	Total	1991-92	1992-93	1993-94	1994-95
Percentage of Projects					
Target Group					
Seniors in general	51	60	67	40	39
Seniors at risk	75	70	66	87	78
Other groups	11	10	11	13	11
n	67	10	9	30	18
Clients					
Seniors in general	55	70	67	50	33
Seniors at risk	51	40	56	57	50
Other groups of seniors	10	0	11	23	6
Other groups	75	70	89	73	67
n	67	10	9	30	18

Clients are those who received financing for or direct services from the project and are distinguished from target groups. As indicated in Table 5.10 most (75 per cent) projects involve clients that are not seniors *per se*; these may be intermediaries such as organizations or individuals such as volunteers whose work will benefit or eventually benefit seniors. More than half of the projects involve seniors in general and/or seniors at risk as clients. The table also shows that the percentage of projects with seniors in general as "clients" has declined over time.

In terms of numbers, only 13 projects provided an indication of how many clients were served by their activities. According to information in the files, most projects had between 100 and 500 clients. The largest number of clients served was approximately 30,000 clients (seniors, in most cases). Clients can involve seniors

and 17 projects indicate that on average, 242 seniors have received some sort of service from them.

Only a true case-study of each project could indicate clearly if or in what way projects introduce a new approach. Many files did not specify how the project contributed to developing the different innovative approaches distinguished for the purpose of this analysis. This is normal considering that this was not a condition for funding. Accordingly, most projects did not introduce new approaches, as indicated in Table 5.11. Most innovative approaches concerned "taking place in a different milieu", "bringing together different stakeholders" and "synthesizing new knowledge". During the time period studied, between 19 and 25 per cent of projects contributed to developing new approaches in these domains.

TABLE 5.11
Seniors Independence Projects with Innovative Approaches

Areas of Innovation	Total	1991-92	1992-93	1993-94	1994-95
	Percentage of Projects				
Approach of the project	9	10	0	13	11
Issue addressed	3	0	0	13	0
Targeting different groups	4	0	0	10	6
Taking place in a different milieu	20	30	22	17	11
Bringing together different stakeholders	19	10	0	33	33
Synthesizing new knowledge	25	33	0	0	67
Other	2	0	0	3	2
n	67	10	9	30	18

It is important to note that unless it was specifically stated that a project was innovative in some way or it was clear to the reviewer that the project was either innovative or not, these questions were coded as "information not in file". Consequently the extent to which projects were innovative may have been underestimated.

Overall, the most common activities included workshops (39 per cent), increasing awareness (35 per cent) and dissemination of information (25 per cent). On average, projects lasted 21 months. Duration varied between one and 46 months.

Slightly more than 70 per cent of files indicated some kind of output or impact from the project. About four projects in 10 offered some services to seniors and three out of ten provided workshops, as indicated above. Nineteen per cent of projects led to or contributed to at least one publication and 13 per cent provided research reports; 21 per cent produced some kind of educational material and 13 per cent provided advice to programs or policies.

Information from 64 files indicate that the average sum provided by DAS/S for these projects was \$137,255; the minimum contribution was \$7,698 and the maximum was \$440,890. Six files provide amounts furnished by other sources; the average contribution was \$35,684 from these other financing sources. In seven files, information on volunteers shows that projects implicated between seven and many hundreds of volunteers. Most involved fewer than 50 volunteers. Most (55 per cent) files do not indicate if the project is or will be self-sufficient after the funding period; 19 project files (28 per cent) indicated that it is or would be the case for the particular project.

Most (36) projects indicate that partnerships³⁹ have been developed through the process (20 did not have the information on file). Of these, seven per cent involved local non-government organizations and 16 per cent were with seniors organizations. Four projects (six per cent) involved partnerships with the federal government and six projects (nine per cent) received funding from the provincial governments (16 per cent in all involved the provincial governments). These findings are presented graphically in Table 5.12.

Strengths of four projects as noted in the files included:

- ☐ use of small groups in one project;
- ☐ volunteer perspective obtained during the planning stage;
- ☐ the community workers were bilingual; and
- ☐ clients actively participated in the activity (participatory theatre).

Weaknesses of four projects noted in the files included:

- ☐ promotion of the project was done after it started;
- ☐ more publicity and more transportation for seniors would have been needed;
- ☐ could not reach some isolated communities because of local resistance; and
- ☐ many caregivers resisted the idea of leaving a senior with a "substitute" caregiver.

39. It should be noted that partnership development was never a formal objective of SIP projects. At its outset (1988), the purpose of SIP was in part to facilitate interdependence with other sectors in society. In 1993, one of the objectives of seniors community programs, including SIP, was the promotion of effective partnerships among seniors, their organizations and other stakeholders for the development of innovative approaches meeting the needs of seniors, particularly at risk.

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TABLE 5.12
Partnerships
(n=36)

Type	% Projects	New Partnership	Joint Decision-Making	Advisory Body	Shared Facilities	Financial Contributions	In-Kind Contributions	Materials	Human Resources	Other	Information Not in File
Federal gov't	6 (n=4)	-	-	-	-	50	25	-	25	-	-
Provincial gov't	9 (n=11)	-	-	18	-	55	9	-	9	-	46
National NGOs	10 (n=10)	-	10	30	-	30	20	-	30	20	30
Regional NGOs	7 (n=8)	11	-	22	-	32	11	-	33	-	33
Local NGOs	16 (n=20)	10	5	15	-	5	15	-	30	5	9
Seniors organizations	16 (n=22)	5	14	18	-	14	18	-	18	9	50
Universities	3 (n=3)	-	-	50	-	25	25	-	-	-	25
Centres of Gerontology	-	-	-	-	-	-	-	-	-	-	-
Independent researcher/s	-	-	-	-	-	-	-	-	-	-	-
Business	6 (n=5)	40	-	-	-	40	40	-	20	-	20
Other Partners	10 (n=8)	-	-	-	-	-	-	-	-	-	-
Other partner 1	-	-	-	-	-	-	-	-	-	-	-
Other partner 2	-	-	-	25	-	25	25	13	25	-	13

Ventures in Independence

The projects funded by this program occurred or were approved between 1993 and 1995. Only 18 files were reviewed for the purpose of this evaluation.

As for the other programs, needs were divided into four broad categories (health and well-being, independence, attitudes towards aging and barriers to participation in society). Since only 18 files were reviewed, a year-sensitive analysis did not seem appropriate. Nonetheless, overall results (Table 5.13) indicate that most financed projects were intended to meet health and well-being needs: between 1993 and 1995, 14 projects out of 18 were related to health and well-being. The other categories received somewhat less attention, as indicated in the table: half and little more than half of projects addressed needs related to attitudes and/or independence. Seven projects addressed needs concerning barriers to participation in society.

TABLE 5.13
Needs Addressed by the Ventures in Independence Projects

Needs	Percentage of Projects (All Years)
Health and well-being	79 (n=14)
Independence	63 (n=11)
Attitudes towards aging	50 (n=9)
Barriers to participation in society	41 (n=7)
Other	16 (n=2)
n (total)	18

The distribution of target groups (the groups which the projects will eventually benefit) is presented in Table 5.14⁴⁰. As indicated, the majority of the projects (14, or 80 per cent of projects) were targeted towards seniors at risk and half towards seniors in general.

Clients (parties who received financing or direct services for the project) were mostly seniors. As indicated in the same table, most (13) clients were seniors in general while 12 involved seniors considered at risk. About half of the projects involved clients that are not seniors *per se*, such as organizations or individual volunteers.

TABLE 5.14
Target Group and Clients of the Ventures in Independence Projects

	Percentage of Projects (All Years)
Target Group	
Seniors in general	50 (n=9)
Seniors at risk	80 (n=14)
Other groups	22 (n=4)
n (total)	18
Clients	
Seniors in general	72 (n=13)
Seniors at risk	69 (n=12)
Other groups of seniors	6 (n=11)
Other groups	49 (n=9)
n (total)	18

40. As projects can target more than one group, the percentages presented will not equal 100.

In terms of numbers, only two projects provided an indication of how many clients and seniors were served by their activities; these served 26 and 100 clients and 100 and 175 seniors.

Most files do not indicate clearly in what way projects introduce a new approach. Again, only an in-depth analysis of each project could indicate clearly in what way new approaches are developed. This of course is beyond the scope of this present evaluation. Still, results indicate that most projects did not bring about new approaches, as presented Table 5.15. No more than three projects fell into any one category of innovation.

It is important to note that unless it was specifically stated that a project was innovative in some way or it was clear to the reviewer that the project was either innovative or not, these questions were coded as "information not in file". Consequently the extent to which projects were innovative may have been underestimated.

TABLE 5.15
Ventures in Independence Projects with Innovative Approaches

Area of innovation	Percentage of Projects (All Years)
Approach of the project	10 (n=2)
Issue addressed	17 (n=3)
Targeting different groups	6 (n=1)
Taking place in a different milieu	11 (n=2)
Bringing together different stakeholders	15 (n=3)
Synthesizing new knowledge	0
Other	10 (n=2)
n (total)	18

Overall, the most frequent activities included providing services (nine projects), workshops (seven projects), consultation with seniors (six projects) and increasing awareness (six projects). The duration of projects varied between five and 49 months and the average is 25 months.

More than half (11) of the projects reported some outputs; the others did not have the information on file. Of the 11, six files indicate that services were provided, one developed policies, five led to workshops, one involved roundtables, another produced educational materials and five developed advice or policies for programs. Two projects led to publications and five to research reports.

Information from these 18 files indicate that the average sum provided by DAS/S for these projects is \$130,746; the minimum contribution was \$10,050 and the maximum was \$436,730. Four files provided amounts furnished by other sources; contributions varied between \$18,320 and \$512,225. Nine projects received in-kind contributions. Only one file provided information on volunteer participation (seven volunteers in that project). Of the 14 out of 18 projects that provided the information, seven projects indicated that their activity would be self-sufficient after the funding period.

According to the files (and presented in Table 5.16), almost every project (17 of 18 projects) involved other partners. Of these, three (18 per cent) involved partnerships with national non-government organizations, six (35 per cent) with regional NGOs and five (29 per cent) with local NGOs. Seniors organizations were partners in eight projects (47 per cent). One project (six per cent) involved a partnership with the federal government and three (18 per cent) with provincial governments (two of which also received financial assistance from their provincial government). Five (29 per cent) activities were undertaken in partnership with businesses and eight with other groups.

No strengths or weaknesses were mentioned in these files.

New Horizons: Partners in Aging

New Horizons: Partners in Aging was initiated in April, 1995 following the amalgamation of New Horizons, the Seniors Independence Program and Ventures in Independence. As the Strategy itself sunsets in March 1997, there will be no funding commitments to NH:PA projects after that date. Of the 42 projects reviewed, nine projects were completed and 33 are still ongoing. The average duration of the projects is 13 months ranging from two months to 18 months.

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TABLE 5.16
Partnerships
(n=18)

Type	% Projects	New Partnership	Joint Decision-Making	Advisory Body	Shared Facilities	Financial Contributions	In-Kind Contributions	Materials	Human Resources	Other	Information Not in File
Federal gov't	6	50	-	-	-	-	-	-	-	-	50
Provincial gov't	18	25	-	-	-	50	-	-	-	-	25
National NGOs	18	-	-	33	-	17	-	-	-	17	50
Regional NGOs	35	-	25	38	-	25	13	-	-13	-	25
Local NGOs	29	-	25	50	-	13	25	-	11	13	38
Seniors organizations	47	-	33	56	-	-	-	-	-	33	11
Universities	-	-	-	-	-	-	-	-	-	-	-
Centres of Gerontology	-	-	-	-	-	-	-	-	-	-	-
Independent researchers	-	-	-	-	-	-	-	-	-	-	-
Business	29	-	-	-	-	33	-	-	-	50	17
Other Partners	47										
Other partner 1	-	33	-	57	-	11	33	-	22	33	11
Other partner 2	-	-	33	67	-	-33	33	33	33	-	33
Other partner 3	-	-	-	50	-	-	-	50	-	-	-

By far the majority of projects reviewed have as their focus the health and well-being of seniors. As Table 5.17 indicates, 91 per cent of projects address health and well being. In comparison, only five per cent of the projects reviewed address attitudes towards seniors. In terms of health and well-being, 19 per cent of projects address social isolation or loneliness, 17 per cent address mental or emotional well-being, 14 per cent address physical well-being and health and eight per cent (or six projects) focus specifically on depression. Senior abuse was another category under health and well-being which gained a great deal of attention from NH:PA projects. Although individual types of abuse did not receive a great deal of emphasis (e.g., only seven per cent of projects addressed physical abuse), when combined (i.e., physical abuse, emotional abuse and financial abuse) they comprise the focus of 11 per cent of projects.

In terms of independence, 11 per cent of projects focused on transportation services. It should be noted that the 11 per cent represents only five projects. In terms of barriers to participation in society, language was the primary barrier addressed (seven per cent). Again, it should be noted that this seven per cent represents only three projects.

TABLE 5.17
Needs Addressed by the New Horizons: Partners in Aging Program

Needs	Percentage of Projects
Health and well-being	91 (n=38)
Independence	38 (n=16)
Attitudes towards aging	5 (n=2)
Barriers to participation in society	31 (n=12)
Other	5 (n=2)
n (total)	42

As Table 5.18 indicates, the majority of projects target seniors at risk (98 per cent) over seniors in general (29 per cent) or other target groups (10 per cent)". As addressing "at risk" is a *sine qua non* condition of NH:PA projects, this finding is not surprising. Of the seniors at risk that were being targeted, socially isolated seniors received the most attention with 26 per cent of projects having this group as their target. The next most frequently targeted groups were women and those who are at risk of abuse or have been abused, with both groups being targeted by 12 per cent of projects.

TABLE 5.18
Target Group and Clients of the New Horizons: Partners in Aging Program

	Percentage of Projects
Target Group	
Seniors in general	29 (n=12)
Seniors at risk	98 (n=40)
Other groups	10 (n=4)
n (total)	42
Clients	
Seniors in general	57 (n=24)
Seniors at risk	69 (n=28)
Other groups of seniors	14 (n=6)
Other groups	55 (n=22)
n (total)	42

41. As projects can target more than one group, the percentages presented will not equal 100.

As Table 5.18 indicates, the primary clients of the New Horizons: Partners in Aging projects are seniors at risk (69 per cent) followed by seniors in general (57 per cent) and other groups (55 per cent). In terms of seniors at risk, the socially isolated were the primary clients (24 per cent). Other clients included seniors organizations, health care professionals, community agencies, families and caregivers.

The activities undertaken by projects varied with no one activity taking precedence. The more common activities, however, included services to seniors (15 per cent), workshops (11 per cent), consultations with seniors or other stakeholders (nine per cent) and dissemination of information (eight per cent).

Thirty-six per cent of all NH:PA projects reviewed clearly indicated being innovative in at least one way, with 29 per cent indicating being innovative in two ways. In light of the fact that innovation is an objective of NH:PA projects, we would have expected this percentage to have been higher. The lower percentage may simply be an underreporting of the fact in the files. More specifically:

- ☐ 22 projects indicated being innovative by utilizing a new approach (e.g., distance education to raise awareness of abuse in rural areas);
- ☐ two projects address a new issue (e.g., technological illiteracy among seniors);
- ☐ three projects target different groups (e.g., senior women of colour caring for grandchildren);
- ☐ four projects take place in a different milieu (e.g., rural area);
- ☐ five projects bring together different stakeholders (e.g., seniors and individuals in transition);
- ☐ three projects have/will develop and synthesize new knowledge (e.g., new resource materials for therapists); and
- ☐ three projects are innovative in other ways (e.g., empowers socially isolated women).

It is important to note that unless it was specifically stated that a project was innovative in some way or it was clear to the reviewer that the project was either innovative or not, these questions were coded as "information not in file". Consequently the extent to which projects were innovative may have been underestimated.

The amount of money received or committed to the New Horizons: Partners in Aging projects varied substantially, ranging from \$2,002 to \$101,000 with the average amount received being \$42,333. In addition to the DAS funding, other sources of funding were noted by a few projects. Four out of the 42 projects indicated receiving (or potentially receiving) money from their partners for an average amount of \$5,400 and one project indicated that the organization itself would be contributing \$30,180 to the project. Contributions from others were also noted, ranging from \$2,750 to \$75,000 with the average amount received being \$15,158.

In addition to financial contributions, in-kind contributions were also noted by almost half of the projects (43 per cent). In-kind contributions ranged from office space, equipment and human resources to meals and entertainment. Although a value for all in-kind contributions was not available, for those in which it was available (10 projects), the average value for in-kind contributions was \$3,605. The range in value was from \$546 to \$8,000.

Self-sufficiency is an issue of concern for New Horizons: Partners in Aging projects which intend to continue once the DAS/S funding ends. Due to the fact that a large number of NH:PA projects reviewed are ongoing, it was not possible to comment on the self-sufficiency of the majority of projects. Of the nine projects for which information was available, all nine projects indicated being self-sufficient following completion of their DAS/S funding. The majority of projects (62 per cent), however, did indicate the intention of becoming self sufficient. For those indicating

that they would be/were self-sufficient, sources of future funding included city councils, sales of publications and seniors and community organizations. There were no actual values of future funding provided. For those projects in which self-sufficiency as a goal was not clearly indicated (38 per cent), it was not possible to determine whether or not the project had or would lead to continuing activities.

Partnerships with other groups/organizations/agencies were developed in the majority of projects (86 per cent)⁴². As partnership development is a sine qua non condition for NH:PA projects, this finding is not surprising. Projects were more likely to form partnerships with seniors organizations (58 per cent) than with anyone else. Next to seniors organizations, partnerships with local NGOs and the provincial government were the most common (56 per cent and 50 per cent respectively). In comparison, partnerships were least likely to be formed with the federal government and independent researchers (three per cent and three per cent respectively). A breakdown of the types of partnerships is presented in Table 5.19.

Table 5.19 also presents a breakdown of the nature of the partnerships that have been developed with each partner. While the type of partnerships developed varied, of note is the percentage of partnerships, regardless of with whom the partnership was developed, that involved the partner as an advisory body. The provision of human resources was another capacity within which partners were more likely to be involved. As will be noted, a number of the activities of partners were categorized under "other". These activities included: referral of seniors; provision of training; promotion; workshops and project development. In terms of partners which fell into the "other" category, these partners include: municipalities; hospitals; media; community health centres; churches, police departments and fire departments. Unfortunately for some cases, although we knew the partnership existed, there was no

42. Partnership development does not include partnership with Health Canada's funding program.

information provided as to the capacity in which the partner was involved. As a number of the cell sizes were very small, the purpose of this table is merely to give the reader an overall sense of with whom or what types of organizations partnerships tend to be developed and in what capacity.

TABLE 5.19
Partnerships
(n=36)

Type	% Projects	New Partnership	Joint-decision making	Advisory Body	Shared Facilities	Financial Contributions	In-Kind Contributions	Materials	Human Resources	Other	Information not in file
Federal gov't	3 (n=1)	-	-	-	-	-	-	-	-	100	-
Provincial gov't	50 (n=18)	6	-	25	3	6	8	6	17	22	8
National NGOs	33 (n=12)	-	-	11	-	-	11	11	22	17	28
Regional NGOs	22 (n=8)	-	-	27	-	-	7	-	13	40	13
Local NGOs	56 (n=20)	5	3	11	5	-	11	8	26	24	8
Seniors organizations	58 (n=21)	9	3	14	3	-	11	6	17	17	20
Universities	14 (n=5)	20	-	40	-	-	-	-	20	-	20
Centres of Gerontology	6 (n=2)	-	-	100	-	-	-	-	-	-	-
Independent researchers	3 (n=1)	-	-	100	-	-	-	-	-	-	-
Business	25 (n=9)	7	-	20	-	13	13	13	13	7	13
Other Partners	42 (n=15)	-	-	30	10	5	10	5	10	10	20
Other partner 1	60	-	-	29	14	-	-	14	14	-	29
Other partner 2	33	-	-	-	100	-	-	-	-	-	-
Other partner 3	7	-	-	-	-	-	-	-	-	-	-

As the majority of projects were ongoing, there was very little information on outputs and results. This information was only available in 10 out of the 42 project files reviewed. Of the few projects reviewed which contained information on outputs, the findings were as follows:

- ☐ two projects provided services (educational activities, transportation);
- ☐ two projects had workshops;
- ☐ one project has provided advice to programs or policies; and
- ☐ seven projects indicated activities towards the implementation of the project had been completed.

Given the close proximity of the launch of NH:PA and this evaluation, most NH:PA projects have not been completed and evaluation reports submitted. Consequently, information on the number of clients or seniors served as well as information on impacts, effects, strengths and weaknesses was not available. There was, however, information on the number of clients (including seniors and non-seniors) served by two projects (mean = 400) and information on the number of seniors (as a sub-set of clients) served by two projects (mean = 400).

In terms of impacts and effects, one project file also noted having had a positive impact on the seniors who were attending the meetings on a regular basis as they all enjoyed the information they were being provided with. In terms of strengths and weaknesses, the number of community partners was noted as a strength of one project and the participation of too many non-isolated seniors in a project geared towards isolated seniors was noted as a weakness in another project.

While information on impacts and effects was limited due to the ongoing nature of the majority of NH:PA projects, following are some of the intended impacts as noted in the project files:

- ☐ senior and family caregivers will be more informed regarding schizophrenia;
- ☐ senior and family caregivers will feel less isolated and alone and will have a greater sense of hope;
- ☐ awareness regarding senior abuse issues would be heightened among community-based organizations, caregivers and seniors themselves;
- ☐ those seniors who participate in the program will have heightened awareness of the services and resources available in the community;
- ☐ greater public and institutional awareness of the needs of the target group;
- ☐ seniors would become educated and trained about senior abuse and actions available to them;
- ☐ multicultural needs of older adults of ethnic communities would be discussed; and
- ☐ health care costs would come down by helping female survivors of sexual abuse eliminate dependency on costly drugs and avoid expensive hospital stays.

Summary

This section represents the review of 256 Senior Community Funding Program project files. Of the files reviewed, 185 were completed and 68 are ongoing. It was unclear for three project files as to whether they had in fact been completed. The discussion to this point has provided detailed information on the findings of the file review as they pertain to each program, including explanations for findings when

required (e.g., program nuances). Here, highlights of findings on key items will be presented. As well, a comparison between programs on these findings will be provided. For ease of reporting, highlights are presented in bullet format.

Needs Addressed

- ☐ Health and well-being is the primary need being addressed by the projects:
 - New Horizons — 89 per cent;
 - SIP — 72 per cent;
 - Ventures — 78 per cent;
 - NH:PA — 95 per cent.
- ☐ Comparatively, attitudes towards seniors has received little focus:
 - New Horizons — 10 per cent;
 - SIP — 13 per cent;
 - Ventures — 28 per cent;
 - NH:PA — 5 per cent.
- ☐ As the statistics above show, a higher percentage of New Horizons and NH:PA projects address health and well-being than do SIP and Ventures.
- ☐ NH:PA is also the least likely of the programs to address attitudes towards seniors.

Target Group

- ☐ For NH:PA and SIP, projects were more likely to have seniors at risk as their primary target group over seniors in general than New Horizons or Ventures:

seniors at risk

- New Horizons — 49 per cent;
- SIP — 79 per cent;
- Ventures — 78 per cent;
- NH:PA — 98 per cent.

seniors in general

- New Horizons — 67 per cent;
- SIP — 46 per cent;
- Ventures — 89 per cent;

- NH:PA — 29 per cent.
- ☐ The high percentage of NH:PA projects having seniors at risk as their target group is not surprising given that it is an objective of the NH:PA program.
- ☐ The lower percentage of New Horizons projects having at risk seniors as their primary target group is also not surprising given that the reorientation of community programs towards "at risk" did not occur until the renewal of the seniors strategy in 1993.

Client Group

- ☐ NH:PA projects are more likely to have seniors at risk as their primary client than seniors in general. In comparison, New Horizons and Ventures are more likely to have seniors in general as their primary client:

seniors at risk

- New Horizons — 34 per cent;
- SIP — 52 per cent;
- Ventures — 67 per cent;
- NH:PA — 67 per cent.

seniors in general

- New Horizons — 76 per cent;
- SIP — 51 per cent;
- Ventures — 72 per cent;
- NH:PA — 57 per cent.

Activities

- ☐ The primary activity of most programs was providing services to seniors:
 - New Horizons — 81 per cent;
 - SIP — 19 per cent;
 - Ventures — 50 per cent;
 - NH:PA — 38 per cent.
- ☐ As the percentages above indicate, New Horizons projects are more likely to provide services to seniors than projects under any other program. This is not surprising given the emphasis placed on service-oriented projects in 1987-88.

- ❑ In comparison to the other programs, SIP projects are more likely to conduct workshops (39 per cent), increase awareness of seniors issues (34 per cent), disseminate information (25 per cent) and conduct public education campaigns (21 per cent) than they are to provide services to seniors.
- ❑ A relatively high percentage of NH:PA and Ventures projects also conduct workshops (29 per cent and 40 per cent respectively) and disseminate information (21 per cent and 22 per cent respectively). Additionally, a large percentage of NH:PA and Ventures projects carry out consultations with seniors and stakeholders (24 per cent and 34 per cent respectively).

Innovative Approaches

- ❑ NH:PA is the only program for which innovation was a requirement. The need for innovative approaches was first addressed in the objectives of the seniors community programs in 1993.
- ❑ NH:PA projects are the most likely to have introduced a new approach:
 - New Horizons — 2 per cent;
 - SIP — 10 per cent;
 - Ventures — 11 per cent;
 - NH:PA — 52 per cent.
- ❑ Ventures projects are the most likely to address a new issue:
 - New Horizons — 2 per cent;
 - SIP — 6 per cent;
 - Ventures — 17 per cent;
 - NH:PA — 5 per cent.
- ❑ NH:PA projects are more likely to target different groups of seniors:
 - New Horizons — 1 per cent;
 - SIP — 6 per cent;
 - Ventures — 6 per cent;
 - NH:PA — 7 per cent.
- ❑ SIP projects are more likely to take place in a different milieu:
 - New Horizons — 2 per cent;
 - SIP — 18 per cent;
 - Ventures — 11 per cent;
 - NH:PA — 10 per cent.

- ☐ Ventures is the most likely to bring different stakeholders together:
 - New Horizons — 2 per cent;
 - SIP — 5 per cent;
 - Ventures — 17 per cent;
 - NH:PA — 12 per cent.
- ☐ NH:PA projects are the most likely to synthesize new knowledge:
 - New Horizons — 1 per cent;
 - SIP — 5 per cent;
 - Ventures — 0 per cent;
 - NH:PA — 7 per cent.

Partnerships

- ☐ NH:PA and Ventures programs are the most likely to have developed partnerships:
 - New Horizons — 25 per cent;
 - SIP — 54 per cent;
 - Ventures — 94 per cent;
 - NH:PA — 86 per cent.
- ☐ This is not surprising given that these are the only two program for which partnership was a formal objective.

It is apparent from the review of the project files that the programs under the Seniors Community Funding Program are addressing the needs of seniors within the context of their program objectives. Given that seniors at risk is the primary target group for NH:PA projects, for example, is not surprising given that it is an objective of the program. The evolution of the other programs towards this objective is reflected in the findings. Additionally, the fact that partnership development is a formal objective of NH:PA and Ventures and not New Horizons and SIP is also highlighted by the findings.

CHAPTER

6

**CURRENT STRATEGIES OF
PROVINCIAL/TERRITORIAL
GOVERNMENTS AND SELECTED
WESTERN INDUSTRIALIZED
COUNTRIES**

6.1 Provincial Programs⁴³

Many provinces have an independent office or directorate which addresses seniors' issues. In most cases, the activities of these structures consists of informing seniors on government services through on-line services and publications, and advising the provincial ministries on seniors' issues. As indicated, the provincial governments who do not have a directorate or office responsible for seniors have either dispersed responsibilities between many ministries and/or have decentralized services to seniors to regional structures, mainly through regional or community health structures. Provincial structures are described in the following sections.

43. More information will be available for the integrated analysis following the interviews with representatives of provincial and territorial governments.

(a) Newfoundland

There is no provincial office or directorate responsible for seniors nor is there an advisory council or body similar to NACA in Newfoundland. The Health Minister of this province currently holds responsibility for seniors issues. Some seniors initiatives targeted towards seniors are supported by the Health Ministry. It is currently providing support for research on the use of medication.

(b) Nova Scotia

The Senior Citizen's Secretariat has the mandate to facilitate the planning and development of services and programs for seniors by coordinating plans, policies and programs presented by provincial departments, and by developing plans, policies and programs for and with seniors in partnership with the responsible provincial departments and other provincial bodies (such as the Nova Scotia Citizen's Commission and voluntary senior's groups).

The mission of the Nova Scotia Senior Citizen's Commission is to conduct, direct and promote fact-finding studies and research related to aging; to seek out and encourage persons interested in providing voluntary services to citizen groups concerned with aging; to promote new activities and social services for senior citizens through voluntary agencies and through all levels of government as may be deemed appropriate, and to perform any duties assigned to the Commission by the Governor-in-Council or the Minister of Community Services. There are no research programs initiatives/programs specifically for seniors in this province.

(c) Prince Edward Island

There is no directorate of office responsible for seniors in PEI. The Minister responsible for seniors is the Minister of Health and Social Services. The province does not have an advisory council but has a Seniors Federation which represents a small percentage of seniors. There is also a Seniors Liaison who is an individual who advocates for Seniors and maintains communications between Federations, other provincial community groups and the Health and Community Agency. There is no funding for research or multisectoral seniors programs.

(d) New Brunswick

Within this provincial government, the Office of Seniors provides a focus for the development of government-wide policies and programs that affect New Brunswick's senior citizens. The Office also works in partnership with community groups in program development.

In addition to a Senior's Guide to Services and Programs, the Office has published other documents of interest to seniors.

(e) Quebec

There is no office or directorate for seniors issues in Quebec. The Minister of Citizens and Citizenship has recently received responsibility for seniors.

The Seniors Council may be considered as the provincial equivalent of NACA in Quebec.

(f) Ontario

There was an Office of Senior's Affairs but it has recently been dissolved. A 1-800 line will soon be available to inform seniors on available services in each ministry. There are two ministers sharing the responsibility for seniors issues, the Minister of Health and a Minister without portfolio. No council or advisory body exists in Ontario but the Ontario Coalition for Seniors provides some linkage across a number of seniors organizations. There are no specific provincial research efforts supported by this province on seniors issues.

(g) Manitoba

In this province, seniors' issues are addressed by the Province of Manitoba Senior's Directorate. Its mission is to inform seniors, assist government on seniors' issues and establish communication links between government and seniors. It offers a 1-800 information line and organizes workshops. The directorate also produces handbooks on government services for seniors and offers assistance to ministries which deal with seniors' issues. There is also an Interdepartmental Committee on senior Abuse.

The Minister responsible for seniors is the Minister of Housing, Urban Affairs and Seniors. The province provides support for research on seniors.

(h) Saskatchewan

No government office or directorate is solely responsible for seniors in Saskatchewan. There is one person responsible for seniors, under the Minister for Social Services; basically, responsibilities have been decentralized directly to the various ministries who deal with seniors' issues. There are no specific research initiatives/programs on seniors administered by the province.

There are no advisory councils or bodies similar to NACA in Saskatchewan but many seniors' associations provide advice to its provincial government.

(i) NorthWest Territories

There is no office or directorate responsible for seniors. There is, however, a Seniors' Advisory Council, which is an NGO that receives funds from the government, and gives advice to the territorial government.

(j) Alberta

The Alberta Community Development Department has very recently formed a Senior's Division. The purpose of this Division is to administer the Alberta Seniors Benefit Program, an income support program designed to assist lower income seniors achieve a greater quality of life.

There is also a customer and information service, which informs seniors through a toll-free line as well as through two offices in Calgary and Edmonton. There are also Seniors Services Centres in five cities, delivered in partnership with Community Development Services.

The Policy and Programs Branch of the division identifies, leads research on and makes recommendations on issues relevant to seniors' current and future well-being. It consults seniors, promotes seniors' issues, advises government and coordinates with other provincial departments. The Branch also administers the Special Needs Assistance Program, which has been introduced to provide assistance to seniors who have been experiencing difficulty meeting their basic needs as a result of changes to provincial seniors' programs over the past three years.

(k) British Columbia

In British Columbia, the Office for Seniors was established in March, 1989, with the mandate to:

- ☐ provide administrative support to the Minister Responsible for Seniors (Minister of Health);
- ☐ provide administrative support to the Seniors' Advisory Council;
- ☐ coordinate government policy and program development related to seniors;
- ☐ provide a contact point for information exchange on policies, programs and services for seniors; and
- ☐ dispel ageist and misinformed attitudes toward aging and seniors.

The Seniors' Advisory Council was established under the *Seniors' Advisory Council Act* in June, 1989, to provide a means of communication between seniors and the Government of British Columbia. The Council is mandated:

- ☐ to advise the Minister on current and future issues of concern to seniors of the Province;
- ☐ to represent the interests of seniors throughout the province; and
- ☐ to maintain close communication links with major seniors' organizations and organizations involved in providing services to seniors.

The province of British Columbia funds coalitions that lead research on seniors issues.

(1) Yukon

Seniors' issues are addressed by the Continuous Care Division of the Health and Social Services of Yukon. The division has direct contact with local senior groups.

6.2 International Strategies

Canada is not the only country facing the challenges of an aging population. In fact, in comparison to other western industrialized countries, as shown in Table 6.1, Canada's population is relatively young (Wolfson, 1991).

TABLE 6.1
Population Age Structures in 1990 (%)

Country	Age		
	0-14	15-65	65+
CANADA	20.8	67.8	11.4
France	20.4	65.8	13.8
Germany	15.1	69.4	15.5
Italy	17.8	68.4	13.8
Japan	18.3	70.3	11.4
United Kingdom	19.1	65.8	15.1
United States	21.8	66.0	12.2

Source: Wolfson, 1991.

As Canada is not alone in its struggle to develop effective policies and programs to meet the needs of seniors, the question becomes: what are other countries doing? In this section, programs, initiatives and strategies being developed by other western industrialized countries (i.e., United States, United Kingdom, France, Germany, Australia, Sweden, Denmark, Norway) will be discussed including, where possible, a discussion of their effectiveness.

(a) Financial Initiatives

All countries reviewed for this study offer some type of pension plan/ income security for seniors once they retire. Of interest, however, are steps taken by some countries to encourage older workers to remain in the labour force for a longer period of time through more flexible retirement options (Aging and Seniors' Policy Review, submitted January 1994). In Sweden and Denmark, for example, workers between the ages of 60 to 64 who continue to work on a part-time basis are offered

partial pensions. The United States encourages workers to defer their retirement by increasing the benefits for those who do and reducing benefits for those who retire early. Finally, France has also taken steps to keep older people in the work force longer by providing various types of subsidies to firms as an incentive to hiring and retaining older workers. Although it is not known to what extent any of these plans work, given the opposition from the private sector to retain older workers who tend to be more highly paid than other employees, as noted in the Aging and Seniors' Policy Review, it would seem that the subsidies provided to firms in France would be the most successful in terms of gaining private sector buy-in.

(b) Health Care Systems

Health care systems are unique to each country. They can, however, be classified according to how they are organized, financed, regulated and delivered (Health Reports, 1993). At one extreme are health systems financed and delivered primarily by the government and at the other extreme are those financed and delivered primarily by the private sector. The discussion of the health care systems and initiatives that have been adopted by the different countries under review will be undertaken in the context of how each country finances and delivers their health care.

Private Health Care Systems

United States

Of the countries reviewed, the United States is the only country whose health care system is predominantly private. While the United States does not have a national health plan that guarantees the right to health care for all citizens, there is a national health program for seniors (Abrams, 1987). Medicare is a federally funded

program which reimburses individuals over the age of 65, as well as some categories of disabled persons, for certain types of medical services. This program was created because of the recognized need for seniors, who are often on fixed incomes, to be able to access expensive medical services for severe illness and disability. Recently Medicare was expanded to cover costs for primary health care such as annual checkups. In terms of long-term care, Medicare only pays for skilled home health services and does not cover the cost of other services, such as help with bathing or toileting, unless they are provided along with skilled service. It is these "personal" services, however, which are most in need by seniors with chronic illnesses.

An additional health plan for seniors is Medicaid (Abrams, 1987). This program, which is administered by the individual states, is cost-shared between the federal government and each state. This program provides funding for acute and long-term care services for the poor, including seniors. Unfortunately only 25 per cent of this target group are actually covered by the program. Medicaid will also pay for nursing home care. The amount that Medicaid pays, however, is less than that received from private patients, resulting in discriminatory behaviour against Medicaid recipients by the nursing homes.

Programs and initiatives to provide or promote in-home or support services to seniors have also been developed. For example, Maryland has a state-funded program which provides community services administered by local agencies (Abrams, 1987). Through this program, a needs assessment is conducted to determine the specific needs of the individual. Based on this assessment, a variety of in-home services, funded by different sources, are coordinated. The United States also offers financial incentives for families who care for seniors (Smith-Barusch, 1995). This is done either through direct payments or tax incentives to the caregiver. When surveyed, caregivers indicated that the amount paid, although small, did help to compensate for lost income. It was noted by the author, however, that there are a

number of subtle, unanticipated costs associated with providing incentives. For example, if the monetary rewards are small, then they may be an ineffective incentive for families to provide care for their seniors. On the other hand, higher monetary rewards may result in seniors being forced into dependency on family members who are providing care strictly for monetary purposes.

In 1965, the *Older Americans Act* came into being (Abrams, 1987). Under this Act, funding was to be provided for supportive services, nutrition services and multi-purpose senior centres. It was felt that by providing the necessary transportation, information, outreach and referral services, seniors would be able to access the necessary health services. While this Act has been in existence for 31 years, due to lack of funding, it has never been effectively implemented.

Finally, there is the *Long-Term Care Ombudsman Program* (Netting, 1995). This Program, which was developed under the *Older Americans Act* but implemented by individual states, was created to address the problems of poorly run nursing home facilities and board and care facilities, as well as possible senior abuse which may occur within these facilities. An initial study on the program's effectiveness conducted between 1979 and 1981 resulted in mixed results due to challenges associated with Program start-up. According to the authors, the Program has also been recently criticized for not having an adequate national reporting system for documenting progress and outcomes.

Predominantly Public

United Kingdom

The United Kingdom offers comprehensive health services to everyone through the British National Health Service and in collaboration with regional and

district health authorities (Health Reports, 1993). Of note in the United Kingdom are the major reforms in the area of residential and nursing-home care (Warnes, 1993). Based on the view that care should be provided, to the extent possible, within a persons' home, the *Registered Homes Act* of 1984 was enacted. Through this Act, private and voluntary sectors were encouraged (through funding) to increase the number of residential care facilities. This Act also took away the responsibility of the local government for providing care and it upgraded inspection and registration. How effective this transition has been is not known. Community services in the United Kingdom, however, have been criticised for being uncoordinated (Aging and Seniors' Policy Review, submitted January 1994).

Sweden

Sweden's health care system is financed, organized and delivered by local governments (Health Reports, 1993). In terms of seniors, the primary objective of Sweden's National policy and programs has been to assist seniors in pursuing a life of continuity, self-determination and to remain in the community for as long as possible (Cates, 1993). There are three main initiatives that have been undertaken by the Swedish government to reduce the institutionalization of seniors. First, during the 1970s, apartments for seniors were constructed which included services such as meals, laundry and homemaking. Second, the government is also committed to providing seniors with permanent home nursing care. Finally, in 1993 the Swedish parliament initiated a program which provided funds for maintenance, repairs and renovations to improve the quality of existing housing for seniors. Although it is difficult to know exactly how much each of these has contributed to the decrease in the number of seniors being institutionalized, the number of institutionalized seniors decreased from approximately 480 per 1,000 in 1980 to 320 per 1,000 in 1985. It is believed, however, that the construction of apartments for seniors has probably had the most effect on

these numbers. As of yet, there is no indication that community care is any more cost effective than institutional care (Cates, 1993).

A more recent innovation has been the coordination and integration of health and social services in one of the long-term care facilities (Cates, 1993). This facility consists of a 67-bed long-term care hospital with a connected primary care centre and a day care centre, and two nursing homes with a total of 78 beds in a building adjacent to it. The focus of this facility is not on the "sick" elements of the senior, but on the healthy parts of the senior that will lend themselves to rehabilitation. In order to achieve maximum improvement in the patient, the activities of the various professionals involved in treating the patient must be tightly coordinated. In this way the quality of care and rehabilitation is improved. There is no indication provided in the literature reviewed for this study, however, as to whether this innovation is effective.

Finally, Sweden has a number of support options for caregivers. For example, informal caregivers can get a 30-day leave with financial assistance and full-time caregivers can receive a direct payment through the local governments (Aging and Seniors' Policy Review, submitted January 1994).

Overall, services in Sweden have been criticized for being inflexible and not being well adapted to the needs of individuals (Aging and Seniors' Policy Review, submitted January 1994).

Denmark

As with Sweden, Denmark's primary objective regarding seniors is developing programs and policies that will enable seniors to remain in their homes and in the community for as long as possible (Cates, 1993). There are two major policies

aimed at reducing the extent of institutionalization of seniors. The *Law on Housing for the Elderly and Persons with Handicaps*, which was put into effect on January 1, 1988, prohibits the construction of additional nursing homes. The *Law on Social Assistance*, which came into effect a year later, provides funding for free permanent home help. It also provides municipalities with the option of paying pensions directly to seniors instead of the nursing home. This would allow a senior to make independent decisions regarding the management of their finances. Additionally, this act removes the financial responsibility of a senior inside an institution from their spouse living in the community. Although it is not known how much the reduction in institutionalization can be attributed to the above, it is worth noting that between 1980 and 1989 there was a reduction in nursing home residents of 23 per cent despite a 5.4 per cent growth in seniors population. Between 1980 and 1989, municipalities in Denmark also increased the number of seniors receiving home help.

In 1986, one of the municipalities in Denmark converted a nursing home into sheltered housing that emphasizes self-care. Basically, each resident receives their own pension and pays only for the care and services they need. Residents also have their own room with a bath, a toilet and cooking facilities. The health care provider is there strictly as a consultant to offer assistance and knowledge on an as-needed basis. Twenty-four hour nursing, however, is available and a doctor is on call. The purpose of this approach is to encourage residents to function independently for as long as possible. Overall the results indicate that residents do have a greater level of independent activity.

Norway

Norway has initiated a number of programs to address the needs of seniors. In terms of housing, the government and municipalities have implemented housing grants aimed at reducing the expenses for households with low incomes

including seniors (Beverfelt, 1993). For example, apartments for seniors have been built in either separate houses or as parts of buildings with family apartments. In rural areas, these types of accommodations are linked to institutions. While the results of a nation-wide survey indicate that this type of housing can reduce the need for residential care, according to the author there is no indication as to whether or not it will reduce nursing home care.

Other types of programs that have been introduced include home-help service, meals-on-wheels, visiting schemes, physical exercise programs and hobby clubs (Beverfelt, 1993). There have also been a number of services implemented that are aimed at meeting seniors' needs regarding safety and independence. For example, the state provides a means-tested subsidy to help offset the costs of telephone installation and subscription expenses. Another program arranges to have volunteers telephone seniors on a periodic basis. If there is no answer when the volunteer calls, the volunteer investigates whether there is a problem. There was no evidence provided in the literature reviewed as to how effective these programs are.

Combination of Private and Public

Health care systems that fall under this category are financed by the public sector but delivered by the private sector (Health Reports, 1993). This is the kind of health care system in Canada.

Australia

As with the other countries already discussed, Australia has developed a number of initiatives aimed at addressing the housing needs and independence of seniors (Andrews and Carr, 1987). These housing initiatives can be traced back to the *Aged Persons Homes Act* (APHA) implemented in 1954. This Act was developed

originally to provide assistance to seniors who needed help with daily living activities, but did not need to be placed in a home (Lefroy, 1993). It was later recognized that there were seniors who needed more care, but still did not need nursing care. This resulted in the development of hostels or residential homes. Seniors have their own room and all meals and housekeeping services are provided. Australia's current policy involves an integrated plan based on a residential program and a community care program (Andrews and Carr, 1987). The primary purpose of this plan is to moderate the growth in nursing home accommodations and to increase the availability of hostel accommodations. Another objective of the plan is to increase the emphasis on community support services for seniors who wish to remain in their own homes. There is no information in the literature located for this review as to the extent to which this integrated plan has been implemented or how effective it has been.

In 1986, the *Home and Community Care Program* was initiated (Lefroy, 1993). It was the intention of this program to improve the quality of life of seniors and disabled people, as well as their caregivers, by developing a comprehensive range of integrated home care and community-based services (Andrew and Carr, 1987). The goal of the program was to provide a realistic alternative to premature or inappropriate institutionalization. According to the authors, the effectiveness of this program has been hindered by the lack of decision making powers on behalf of individual states, resulting in a lack of efficiency, and individual states utilizing the program as a means of reducing hospital expenditures as opposed to an alternative for institutionalization.

France

France's initiatives for addressing the needs of seniors have focused on improving the living situation of seniors and in creating more home care options for seniors wanting to remain in their homes (Fontaine, 1993). Since 1957, attempts have been made to improve the quality of life of seniors living in institutions. Attention has

also been paid to the modernization of the old "hospices" which were built around the beginning of the century as well as renovations to improve older homes through grants (Aging and Seniors' Policy Review, submitted January 1994). Collective houses or apartments are also being developed. Home care options include home-helpers and medical and nursing services which cover basic-life activities not provided by home-helpers. There was no information in the literature reviewed for this study as to the effectiveness of these initiatives.

Germany

The health care needs of seniors, particularly those with chronic illness, has become an issue of public concern. The need to develop a new system of financing to care for the frail elderly in institutions and at home has been recognized (Dieck and Thomae, 1993). Information on the extent to which this insurance program is effectively addressing these health care needs was not provided in the literature reviewed.

(c) International Year of Older Persons

The *International Year of Older Persons* is a strategy currently being undertaken by countries around the world. The *International Year of Older Persons* will be observed in 1999 as part of the evolution of the United Nations program on aging (United Nations, *General Assembly*, Fiftieth Session). The overall objective of this Year is to promote and implement into policies, programs and actions the United Nations Principles for Older Persons. There are 18 Principles which have been categorized into five issue areas: independence; participation; care; self-fulfilment; and dignity.

To address these five issue areas, a conceptual framework with four dimensions has been developed:

- ☐ the situation of older persons;
- ☐ life-long individual development;
- ☐ multi-generational relationships; and
- ☐ the development and aging of populations.

It is believed that these four dimensions will enable the further discussion and debate of the five issue areas.

Given that aging is a multi-dimensional, multi-sectoral and multi-generational issue, it seemed appropriate that the theme for the Year be one that encompasses the concept of "a society for all ages". Consequently, the theme that has been decided upon is: *Towards a Society for All Ages*. This broad theme opens up the potential for participation by all generations and the involvement of many organizations and sectors.

As the Year is only three years away, promotional activities are underway. For example, NGOs have been invited to develop programs and projects for the Year, particularly at the local level. Having already received 60 contributions from 25 countries, including national organizations and NGOs, the United Nations is optimistic that the Year will be well supported (United Nations, *General Assembly, Fiftieth Session*). Canada's contribution to the Year was a topic of discussion at the *Connection '95* conference in Quebec. It was reported at this conference that the Minister of Health had initiated a dialogue and the DAS had started disseminating information on the Year through their publications and through interdepartmental provincial and federal networks of officials to seniors organizations. While the Canadian theme for the Year is still up for debate, ideas for possible projects (e.g., a commemorative stamp, elementary school projects) have started to surface. It is felt that the role of the federal government should be one of leadership and promotion, leaving the organization of local projects to seniors organizations.

(d) Summary

This overview of programs and initiatives being implemented by other countries indicates a trend towards community-based care. Most of the policies and initiatives are also similar to those being implemented in Canada. In terms of lessons learned for Canada, the effectiveness of most of these programs was not discussed in the literature reviewed. It is also important to remember the differences in political organization and social philosophies of the different countries (Aging and Seniors' Policy Review, submitted January 1994). In other words, what works in one country may not necessarily work in another. Additional factors which may effect adaptability of another country's programs are differences in the cost of living and the existence of other benefits (e.g., food stamps, subsidized housing) which may not be known (Baker, 1988).

6.3 Summary

As this chapter has demonstrated, seniors' issues are of concern to not only the federal government of Canada, but provincial/territorial governments and the governments of other western industrialized nations. While the strategies and initiatives undertaken by these various governments differ, there is a general trend towards community-based care and the involvement of volunteer and community organizations/agencies in providing services to seniors. Many of the provincial/territorial governments have established Offices or Directorates to provide information to seniors and advice to the provincial/territorial government. As already noted, where these types of Offices do not exist, responsibilities for services to seniors, in most

cases, have been decentralized to the ministries or regional structures more directly involved with seniors. The overriding concern of all governments regarding seniors is their continued health, well-being and independence.

CHAPTER

7

CONCLUSION

This report presented the results from the literature, baseline data and some of the file reviews conducted as part of the evaluation of the Division of Aging and Seniors/Seniors Strategy. These sources offer vital information and views about seniors in Canada and the relevance of DAS/S and other programs like it in other countries. In particular, the literature review and baseline data review provide useful information about seniors in general, seniors at risk, how to address the problems these seniors experience and how current policies have addressed them recently. The file review gives basic information on some of the projects funded by DAS/S.

This review raises many issues and questions that may also be discussed by the respondents during the remaining interviews to be conducted for this evaluation. In particular, interviewers should expect the following issues to be raised during the interviews and probe when felt necessary:

- The literature indicates that most seniors are women and that more senior women than men have lower income, have access to less means of transportation and live alone. The literature also suggests that Aboriginal seniors experience more health problems than non-Aboriginal seniors. Small-town and rural seniors may also be considered at risk. It will be interesting to see if these groups will also be identified by

those who will be interviewed and to hear their comments on how DAS/S addresses the needs of these "at-risk" groups.

- ❑ Past and future trends of formal and informal support suggest that there will be fewer informal caregivers available in the future. Experts believe that this will spur demand for formal support, while more support will be needed for those informal caregivers in place. What will be DAS/S' contribution to these challenges? Have DAS/S interventions to support informal and formal caregivers been effective in the past? This issue will be kept in mind by interviewers when discussing program accomplishments with respondents.
- ❑ Circulation and dissemination of data and research results has not always been effective in the past. According to the literature, data exchanges between provinces, in particular, have not always been effective. It will be interesting to see if this issue will be raised by provincial officials.
- ❑ Review of DAS/S documents and files indicate that at some point of time, priority was given to projects that deal with "at-risk" seniors. Health Canada's (and DAS) mandate, however, indicates that promoting prevention is an important aspect of its mission. Therefore, could it be that the targeting of "at-risk" seniors is done to the detriment of "prevention" activities?
- ❑ In reviewing DAS/S files, it appears that many funding recipients do not evaluate their own projects or do not do so in an adequate manner. Has DAS/S taken the necessary measures to ensure this self-evaluation? Would there be ways of ensuring that these evaluations are undertaken and done in a useful manner? Interviews with Health Canada personnel should indicate if there is a felt need for change in these practises in the "Alternatives" section of the guide.
- ❑ DAS/S funded projects revealed themselves to be quite varied; some gave impressive results while others seemed more or less useful. Although progress has been achieved in time, a question remains: is the project selection procedure effective? Are DAS/S funding programs accessible and equally accessible in all regions? Are they well known? Again, interviews with Health Canada personnel, as well as stakeholders and successful/unsuccessful funding recipients, will indicate if this is an issue or not.
- ❑ Concerning public policies and services to seniors, there is an important decentralization trend of health and social services. This is true in

Canada and its regions and provinces, as well as in other countries. Has the work of DAS/S been effective in addressing this issue? What will it mean for DAS/S in the future? Interviewers will keep this in mind for all interviews and encourage respondents to develop their answers on this if the issue is raised by them.

- Many seniors want to stay at home and many provincial governments want to reduce the institutionalisation rate among seniors. In many cases, this is linked to the decentralization process currently occurring. Has DAS/S addressed this expressed need by both parties? Has DAS/S addressed the "risks" involved in this process? According to the literature, this is an important issue and it will be interesting to see how many respondents will raise it during interviews.

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APPENDIX A
ABBREVIATIONS

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ABBREVIATIONS

CATI	Computer Assisted Telephone Interviewer
CIS	Contribution Information System
DAS	Division of Aging and Seniors
DAS/S	Division of Aging and Seniors/Seniors Strategy
HPPBRO	Health Promotion and Programs Branch Regional Offices
NACA	National Advisory Council on Aging
NGO	Non-governmental Organization
NH	New Horizons Program
NH:PA	New Horizons: Partners in Aging Program
NHRDP	National Health Research and Development Program
PCB	Policy and Consulation Branch
SIP	Seniors Independence Program
SIRP	Seniors Independence Research Program
SITS	Seniors Inquiry Tracking System

APPENDIX B
DAS/S EVALUATION FILE REVIEW GUIDE

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DAS/S Evaluation File Review Guide

1:

DOCUM

Indicate which program file documents have been received

01	Funding Approval form	01
02	Application	02
03	Activity and Accounting Report	03
04	Impact Questionnaire	04
05	Interim Reports	05
06	Quarterly Narratives	06
07	Final Report	07
08	Evaluation Report	08
09	Other	09
10	PROPOSAL (PART/WHOLE)	10

2:

Q1

Indicate Program

01	NH:PA	1
02	NH	2
03	SIP	3
04	Ventures	4
05	NACA	5
06	SIRP	6
07	Internal Projects	7

3:

Q2A

What is the name of the project?

01	Response	1	O
----	----------	---	---

4:

Q2B

What is the project number?

5:

Q3

What is the year category?

01	1991-92	1
02	1992-93	2
03	1993-94	3
04	1994-95	4
05	1995-96	5

6:

Q4A

What is the project's duration (in months)?

01	Information not in file	9999
----	-------------------------	------

SE

7:

Q4B

Is the project completed or ongoing?

01	Completed	1
02	Ongoing	2
03	Information not in file	9

8:

Q5

What are the project's objectives?

01	Objective	01	O
02	Information not in file	99	

9:

Q6A

Does the project address health and well-being?

01	Yes (definition)	01	O
02	No	02	
03	Information not in file	99	
04	MENTAL/EMOTIaL WELL-BEING OR SUPPORT	11	
05	PHYSICAL WELL-BEING OR HEALTH (PREVENTION)	12	
06	ABUSE - PHYSICAL	13	
07	ABUSE - EMOTIONAL	14	
08	ABUSE - DRUG AND ALCOHOL	15	
09	ABUSE - FINANCIAL	16	
10	SOCIAL ISOLATION / LONELINESS	17	
11	GEOGRAPHIC ISOLATION	18	
12	POOR NUTRITION	19	
13	DEPRESSION	20	
14	CHRONIC ILLNESS	21	
15	DEMENTIA	22	
16	DISABLED SENIORS	23	
17	SAFETY	24	

10: Q6B

Does the project address seniors independence?

01	Yes (definition)	01	O
02	No	02	
03	Information not in file	99	
04	TRANSPORTATION SRVs	11	
05	INFO ON PRGs & SRVs	12	
06	MEALS BROUGHT TO HOME	13	
07	CONGREGATE MEALS	14	
08	HOME VISITS/IN-HOME SUPPORTS	15	
09	MISC. ALLOW SRs TO REMAIN HOME/INDEP.	16	
10	ASSIST DISABLED SRs (BLIND, MOBILITY)	17	
11	IMPROVES LITERACY	18	
12	EDUC (FIANC, HEALTH, CDN CULT. COOKING etc.)	19	
13	SUPPORT (PEER, VOLUNts)	20	
14	ACTIVs IN COMMUN. TO ENCOURAGE INDEP.	21	
15	HOUSING	22	
16	SECURITY/SAFETY	23	
17	OTH ("DYING w/DIGNITY", SELF FUNDING, INCM SECUR.)	24	

11: Q6C

Does the project address attitudes towards aging?

01	Yes	1	
02	No	2	
03	Information not in file	9	

12: Q6D

Does the project address barriers to seniors involvement/participation in society?

01	Yes (definition)	01	O
02	No	02	
03	Information not in file	99	
04	LANG. BARRIER	11	
05	TRANSPORTATION	12	
06	PROVIDE PLACE & OPPORT. SRs CAN MEET	13	
07	ACTs ENCOURAGE PARTICIPATION	14	
08	ADDRESS BARRIERS FOR DISABLED/ILLITERATE SRs	15	
09	TARGET ISOLATED SRs TO ACTIVE	16	
10	INFO/EDUC TO SRs ABOUT SRVs	17	
11	OTHERS	18	

13: Q6E

Are there other needs that this project is addressing?

01	Yes (need)	01	O
02	No	02	
03	Information not in file	99	

14: Q7A
Does this project target seniors in general?

01	Yes	1
02	No	2
03	Information not in file	9

15: Q7B
Does this project target seniors at risk?

01	Yes (risk)	01	O
02	No	02	
03	Information not in file	99	
04	RURAL/REMOTE	11	
05	WOMEN	12	
06	SOCIALLY ISOLATED	13	
07	LOW INCOME	14	
08	LOW LITERACY	15	
09	DEMENTIA/MENTALLY ILL	16	
10	VERY OLD SRs(FRAIL)	17	
11	DISABLE/HOME BOUND	18	
12	ABUSED/RISK OF ABUSED	19	
13	LANG. BARRIER	20	
14	ETHNIC MINORITIES	21	
15	NATIVE/ABORIGINAL	22	
16	CHRONICALLY/RECUR HEALTH PROBs	23	

16: Q7C
Does this project target any other group?

01	Yes (group)	01	O
02	No	02	
03	Information not in file	99	

17: Q8A
Are the clients of this project seniors in general?

01	Yes	1
02	No	2
03	Information not in file	9

18:

Q8B

Are the clients of this project seniors at risk?

01	Yes (risk)	01	O
02	No	02	
03	Information not in file	99	
04	RURAL/REMOTE	11	
05	WOMEN	12	
06	SOCIALLY ISOLATED	13	
07	LOW INCOME	14	
08	LOW LITERACY	15	
09	DEMENTIA/MENTALLY ILL	16	
10	VERY OLD SRs(FRAIL)	17	
11	DISABLE/HOME BOUND	18	
12	ABUSED/RISK OF ABUSED	19	
13	LANG. BARRIER	20	
14	ETHNIC MINORITIES	21	
15	NATIVE/ABORIGINAL	22	
16	CHRONICALLY/RECUR HEALTH PROBs	23	

19:

Q8C

Are the clients of this project other groups of seniors?

01	Yes (group)	01	O
02	No	02	
03	Information not in file	99	
04	SRs ORGANIZATION	11	
05	VOLUNTEERS	12	
06	CAREGIVERS	13	

20:

Q8D

Are any of the following groups clients of this project?

01	No	01	
02	Minister of Health	02	
03	Minister Responsible for Seniors	03	
04	Federal government	04	
05	Other government departments	05	
06	Provinces/territories	06	
07	Independent researchers	07	
08	Universities	08	
09	Centres of Gerontology	09	
10	NGOs: national	10	
11	NGOs: regional	11	
12	NGOs: local	12	
13	NGOs: Public/consumers	13	
14	Private sector	14	
15	International clients	15	
16	Other (specify)	16	O
17	Information not in file	99	

21:

Q9

What are this project's activities?

01	Providing services to seniors	01	
02	Research	02	
03	Conferences	03	
04	Workshops	04	
05	Monitoring of senior's health problems	05	
06	Dissemination of information	06	
07	Policy development	07	
08	Communications	08	
09	Coordinates seniors initiatives: federal level/interdepartmental	09	
10	Coordinates seniors initiatives: provincial or territorial level	10	
11	Coordinates seniors initiatives: local level	11	
12	Coordinates seniors initiatives: interdepartmental	12	
13	Coordinates seniors initiatives: NGOs	13	
14	Coordinates seniors initiatives: private sector	14	
15	Public education campaigns	15	
16	Knowledge development	16	
17	Funding of community projects	17	
18	Funding of research programs	18	
19	Consultation with seniors or other stakeholders	19	
20	Education to professionals	20	
21	Increasing awareness of seniors issues	21	
22	Partnership development	22	
23	Other (specify)	23	☐

22:

Q10A

Has this project contributed to developing an innovative approach by introducing a new approach?

01	Yes (approach)	01	☐
02	No	02	
03	Information not in file	99	

23:

Q10B

Has this project contributed to developing an innovative approach by addressing a new issue?

01	Yes (issue)	01	☐
02	No	02	
03	Information not in file	99	

24:

Q10C

Has this project contributed to developing an innovative approach by targeting different groups of seniors?

01	Yes (group)	01	☐
02	No	02	
03	Information not in file	99	

25:

Q10D

Has this project contributed to developing an innovative approach by taking place in a different milieu (e.g., rural/urban)?

01	Yes (milieu)	01	☐
02	No	02	
03	Information not in file	99	

26:

Q10E

Has the project contributed to developing innovative approaches by bringing together different stakeholders?

01	Yes (stakeholders)	01	☐
02	No	02	
03	Information not in file	99	

27:

Q10F

Has the project contributed to developing innovative approaches by developing and synthesizing new knowledge?

01	Yes (knowledge)	01	☐
02	No	02	
03	Information not in file	99	

28:

Q10G

Has this project contributed to developing an innovative approach in any other way?

01	Yes (method)	01	☐
02	No	02	
03	Information not in file	99	

29:

Q11

Has this project required any financial resources?

01	Yes	1	
02	No	2	=> Q11C
03	Information not in file	9	=> Q11C

What financial resources has this project required?

DAS/S: @q11a
 Partners: @q11b
 Your organization: @q11aa
 Others: @q11bb

Round to the nearest dollar. Do not put in commas.
 If the information is not provided in the file - 99999999
 If NA - leave blank

30: **Q11A**
DAS/S

31: **Q11B**
Partners

32: **Q11AA**
Your Organization

33: **Q11BB**
Others

34: **Q11C**
Were there any in-kind contributions?

01	Yes	1	
02	No	2	=> Q11D
03	Information not in file	9	=> Q11D

Were there any in-kind contributions and, if possible, what was their value?

Contrib 1: @q11ca	Value 1: @q11c1
Contrib 2: @q11cb	Value 2: @q11c2
Contrib 3: @q11cc	Value 3: @q11c3
Contrib 4: @q11cd	Value 4: @q11c4
Contrib 5: @q11ce	Value 5: @q11c5
Other: @q11cf	Value: @q11co

Round to the nearest dollar. Do not use commas.

35: **Q11CA**
Contribution 1

36: **Q11C1**
Value 1

SE

37: **Q11CB**
Contribution 2

- 38: **Q11C2**
Value 2
SE
- 39: **Q11CC**
Contribution 3
- 40: **Q11C3**
Value 3
SE
- 41: **Q11CD**
Contribution 4
- 42: **Q11C4**
Value 4
SE
- 43: **Q11CE**
Contribution 5
- 44: **Q11C5**
Value 5
SE
- 45: **Q11CF**
Contribution - other
- 46: **Q11CO**
Value- other
SE

47: Q11D
How many volunteers assist with this project's activities?

01	None	000	=> Q12	SE
02	N/A	998	=> Q12	
03	Information not in file	999	=> Q12	

48: Q11E1
How much time (in hours) has been spent by volunteers (in total) during the duration of this project?

01	Information not in file	9999		SE
----	-------------------------------	------	--	----

49: Q12
If a funded project, will the project be self-sufficient once funding ends?

01	Yes	1		
02	No	2	=> Q12F	
03	Information not in file	9	=> Q12F	

Where will funding come from and, if possible, what will be the amount?

Source 1: @q12a	Value 1: @q12a1
Source 2: @q12b	Value 2: @q12b1
Source 3: @q12c	Value 3: @q12c1
Source 4: @q12d	Value 4: @q12d1
Source 5: @q12e	Value 5: @q12e1
Other: @q12o	Other: @q12o1

Round to the nearest dollar. Do not use commas.

50: Q12A
Source 1

51: Q12A1
Value 1

SE

52: Q12B
Source 2

53:	Q12B1 Value 2	\$E
54:	Q12C Source 3	
55:	Q12C1 Value 3	\$E
56:	Q12D Source 4	
57:	Q12D1 Value 4	\$E
58:	Q12E Source 5	
59:	Q12E1 Value 5	\$E
60:	Q12O Source - other	
61:	Q12O1 Value - other	\$E

- 62: Q12F**
If the project does not have self-sufficiency as a goal, has this project led to continuing activities?
- | | | | |
|----|-------------------------|----|---|
| 01 | Yes (activity) | 01 | O |
| 02 | No | 02 | |
| 03 | N/A | 98 | |
| 04 | Information not in file | 99 | |
- 63: PRE13**
Have you developed partnerships with other groups/organizations/agencies?
- | | | | |
|----|---------------------------|---|----------|
| 01 | Yes | 1 | |
| 02 | No partnerships developed | 2 | => PRE14 |
| 03 | N/A | 3 | => PRE14 |
| 04 | Information not in file | 9 | => PRE14 |
- 64: Q13A**
In what capacity has partnership with the FEDERAL GOVERNMENT been developed?
- | | | | |
|----|--|----|---|
| 01 | No partnership has been developed | 01 | |
| 02 | This is a new partnership | 02 | |
| 03 | Joint-decision making | 03 | |
| 04 | Advisory body | 04 | |
| 05 | Shared facilities | 05 | |
| 06 | Financial contributions - in addition to the funding provided by DAS/S | 06 | |
| 07 | In-Kind contributions | 07 | |
| 08 | Materials | 08 | |
| 09 | Human Resources | 09 | |
| 10 | Other (specify) | 10 | O |
| 11 | Information not in file | 99 | |
- 65: Q13B**
In what capacity has partnership with the PROVINCIAL/TERRITORIAL GOVERNMENT been developed?
- | | | | |
|----|--|----|---|
| 01 | No partnership has been developed | 01 | |
| 02 | This is a new partnership | 02 | |
| 03 | Joint-decision making | 03 | |
| 04 | Advisory body | 04 | |
| 05 | Shared facilities | 05 | |
| 06 | Financial contributions - in addition to the funding provided by DAS/S | 06 | |
| 07 | In-Kind contributions | 07 | |
| 08 | Materials | 08 | |
| 09 | Human Resources | 09 | |
| 10 | Other (specify) | 10 | O |
| 11 | Information not in file | 99 | |

66: Q13C

In what capacity has partnership with NGOs: NATIONAL been developed?

01	No partnership has been developed	01
02	This is a new partnership	02
03	Joint-decision making	03
04	Advisory body	04
05	Shared facilities	05
06	Financial contributions - in addition to the funding provided by DAS/S	06
07	In-Kind contributions	07
08	Materials	08
09	Human Resources	09
10	Other (specify)	10
11	Information not in file	99

O

67: Q13D

In what capacity has partnership with NGOs: REGIONAL been developed?

01	No partnership has been developed	01
02	This is a new partnership	02
03	Joint-decision making	03
04	Advisory body	04
05	Shared facilities	05
06	Financial contributions - in addition to the funding provided by DAS/S	06
07	In-Kind contributions	07
08	Materials	08
09	Human Resources	09
10	Other (specify)	10
11	Information not in file	99

O

68: Q13E

In what capacity has partnership with NGOs: LOCAL been developed?

01	No partnership has been developed	01
02	This is a new partnership	02
03	Joint-decision making	03
04	Advisory body	04
05	Shared facilities	05
06	Financial contributions - in addition to the funding provided by DAS/S	06
07	In-Kind contributions	07
08	Materials	08
09	Human Resources	09
10	Other (specify)	10
11	Information not in file	99

O

69: Q13F

In what capacity has partnership with SENIORS ORGANIZATIONS been developed?

01	No partnership has been developed	01
02	This is a new partnership	02
03	Joint-decision making	03
04	Advisory body	04
05	Shared facilities	05
06	Financial contributions - in addition to the funding provided by DAS/S	06
07	In-Kind contributions	07
08	Materials	08
09	Human Resources	09
10	Other (specify)	10
11	Information not in file	99

O

70: Q13G

In what capacity has partnership with UNIVERSITIES been developed?

01	No partnership has been developed	01
02	This is a new partnership	02
03	Joint-decision making	03
04	Advisory body	04
05	Shared facilities	05
06	Financial contributions - in addition to the funding provided by DAS/S	06
07	In-Kind contributions	07
08	Materials	08
09	Human Resources	09
10	Other (specify)	10
11	Information not in file	99

O

71: Q13H

In what capacity has partnership with CENTRES OF GERONTOLOGY been developed?

01	No partnership has been developed	01
02	This is a new partnership	02
03	Joint-decision making	03
04	Advisory body	04
05	Shared facilities	05
06	Financial contributions - in addition to the funding provided by DAS/S	06
07	In-Kind contributions	07
08	Materials	08
09	Human Resources	09
10	Other (specify)	10
11	Information not in file	99

O

72: **Q13I**
In what capacity has partnership with INDEPENDENT RESEARCHERS been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

73: **Q13J**
In what capacity has partnership with BUSINESS been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

74: **Q13K**
If a partnership has been developed with OTHER GROUPS, in what capacity has partnership with the first group been developed?

01	No other partnership has been developed	01	=> PRE14
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

75: **Q13K1**
Specify the name of the first group

01	Response	01	O
----	----------	----	---

- 76: Q13L**
In what capacity has partnership with a second group been developed?
- | | | | |
|----|---|----|----------|
| 01 | No other partnership has been developed | 01 | => PRE14 |
| 02 | This is a new partnership | 02 | |
| 03 | Joint-decision making | 03 | |
| 04 | Advisory body | 04 | |
| 05 | Shared facilities | 05 | |
| 06 | Financial contributions | 06 | |
| 07 | In-Kind contributions | 07 | |
| 08 | Materials | 08 | |
| 09 | Human Resources | 09 | |
| 10 | Other (specify) | 10 | O |
| 11 | Information not in file | 99 | |
- 77: Q13L1**
Specify the name of the second group
- | | | | |
|----|----------------|----|---|
| 01 | Response | 01 | O |
|----|----------------|----|---|
- 78: Q13M**
In what capacity has partnership with a third group been developed?
- | | | | |
|----|---|----|----------|
| 01 | No other partnership has been developed | 01 | => PRE14 |
| 02 | This is a new partnership | 02 | |
| 03 | Joint-decision making | 03 | |
| 04 | Advisory body | 04 | |
| 05 | Shared facilities | 05 | |
| 06 | Financial contributions | 06 | |
| 07 | In-Kind contributions | 07 | |
| 08 | Materials | 08 | |
| 09 | Human Resources | 09 | |
| 10 | Other (specify) | 10 | O |
| 11 | Information not in file | 99 | |
- 79: Q13M1**
Specify the name of the third group
- | | | | |
|----|----------------|----|---|
| 01 | Response | 01 | O |
|----|----------------|----|---|
- 80: PRE14**
Have there been any outputs or results?
- | | | | |
|----|-------------------------------|---|---------|
| 01 | Yes | 1 | |
| 02 | No | 2 | => Q14B |
| 03 | N/A | 3 | => Q14B |
| 04 | Information not in file | 9 | => Q14B |

81:	Q14A1		
	Have services been provided to seniors?		
	01 Yes (service)	01	O
	02 No	02	
	03 Information not in file	99	
	04 MEALS	11	
	05 SOCIAL ACTs(GAMES,FIELD TRIPS)	12	
	06 EDUC. ACTs(SPEAKER,CLASS)	13	
	07 CRAFT ACTs	14	
	08 VISITS	15	
	09 HEALTH ACTs(FITNESS CLASS)	16	
	10 HEALTH VISITS(FOOT CLINIC,COUNSELLING)	17	
	11 TRANSPORTATION	18	
	12 TRAINING	19	

82:	Q14A2		
	How many publications have been published?		
	01 None	000	SE
	02 Information not in file	999	

83:	Q14A3		
	How many research reports have been produced.		
	01 None	000	SE
	02 Information not in file	999	

84:	Q14A4		
	Have there been any policies developed?		
	01 Yes	1	
	02 No	2	
	03 Information not in file	9	

85:	Q14A5		
	Have there been any workshops?		
	01 Yes	1	
	02 No	2	
	03 Information not in file	9	

86: Q14A6

Have there been any roundtables?

01	Yes	1
02	No	2
03	Information not in file	9

87: Q14A7

Have educational materials been produced?

01	Yes	1
02	No	2
03	Information not in file	9

88: Q14A8

Has advice to program or policies been provided?

01	Yes	1
02	No	2
03	Information not in file	9

89: Q14A9

Has advice to the Minister been provided?

01	Yes	1
02	No	2
03	Information not in file	9

90: Q14AO

Have there been any other outputs or products?

01	Yes (output)	01	O
02	No	02	
03	Information not in file	99	
04	IMPLEMENTATION OUTPUTS	11	
05	BROCHURE/POSTER	12	
06	VIDEO	13	
07	TRAINING	14	
08	MEDIA	15	
09	CONFERENCE/PRESENTATION	16	
10	DEVELOP SUPPORT NETWORK	17	

91: Q14B

How many new projects have been created due to the activities of this current project?

01	None	00	SE	=> Q14C
02	N/A	98		=> Q14C
03	Information not in file	99		=> Q14C

- 92: **Q14B1**
What types of new projects have been created?
01 Yes (type) 01 O
02 Information not in file 99
- 93: **Q14C**
How many clients in total have been served?
01 None 000 SE
02 N/A 998
03 Information not in file 999
- 94: **Q14D**
How many seniors have been served?
01 None 000 SE
02 N/A 998
03 Information not in file 999
- 95: **Q15A**
Has an evaluation of this project been completed?
01 Yes 1
02 No 2 => Q16A
- 96: **Q15B**
What is the quality of this evaluation?
01 Very poor 1
02 Poor 2
03 Fair 3
04 Good 4
05 Very good 5
06 Information not in file 9 => Q16A
- 97: **Q15C**
Why did you give the quality of the project evaluation the rating that you did in Q15B?
01 Specify 01 O

98: Q16A

What have been the impacts and effects to date?

- | | | | |
|----|-------------------------------|-----|---|
| 01 | Impacts | 001 | O |
| 02 | No impacts or effects | 002 | |
| 03 | Information not in file | 999 | |

99: Q16B

Have there been any unplanned effects - either positive or negative (e.g., overlap with similar projects, complaints by provincial/territorial governments)?

- | | | | |
|----|-------------------------------|-----|---|
| 01 | Effects | 001 | O |
| 02 | No | 002 | |
| 03 | Information not in file | 999 | |

100: Q17A

What are the strengths of this project (specify only if noted in the file information)?

- | | | | |
|----|--------------------------------------|----|---|
| 01 | Strengths | 01 | O |
| 02 | No strengths noted in the file | 02 | |

101: Q17B

What are the weaknesses of this project (specify only if noted in the file information)?

- | | | | |
|----|---------------------------------------|----|---|
| 01 | Weaknesses | 01 | O |
| 02 | No weaknesses noted in the file | 02 | |

102: DONE

Is there any additional/outstanding information yet to be entered?

- | | | | |
|----|-------------|---|---|
| 01 | Yes | 1 | D |
| 02 | No | 2 | |
| 03 | DK/NR | 9 | |

103: INT

Do you want to close this file for good or do you want the opportunity to come back to it?

- | | | | |
|----|---------------------------------------|---|---------|
| 01 | Close it for good | 1 | => SURE |
| 02 | File it away for re-entry later | 2 | => CB |

104: SURE

Are you sure you want this case for good? IT WILL NOT BE RETRIEVABLE AFTERWARDS!

- | | | | |
|----|-----------|---|----------|
| 01 | Yes | 1 | => END |
| 02 | No | 2 | D => INT |

105: CB

Are you sure you want to store this file in your "call-backs" for further references?

01	Yes	1	D	=> END
02	No	2		=> INT

106: TOEND

=> END if 0==0

107: DUM_1

=> END if 0==0

108: DUM_2

109: DUM_5

=> Q11C if 0==0

110: DUM_8

111: DUM_9

112: DUM10

